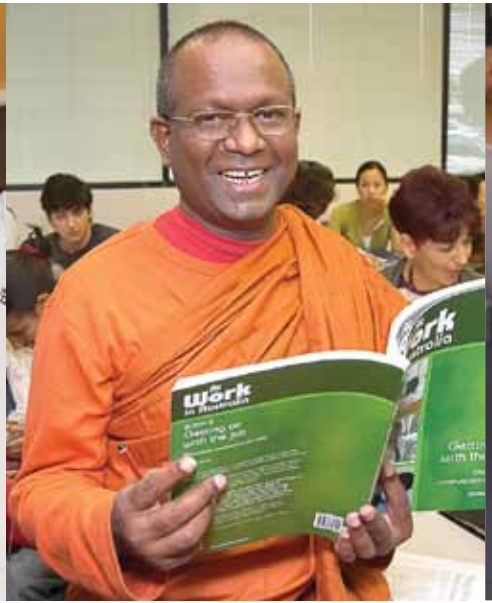
Promoting Refugee Health

A guide for doctors, nurses and other health care providers caring for people from refugee backgrounds

3RD EDITION

> HOW TO NAVIGATE THIS ONLINE GUIDE







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DISCLAIMER while best efforts have been made to ensure the accuracy of the information presented in this publication, readers are reminded that it is a guide only. It is understood that health practitioners will remain vigilant to their clinical responsibilities and exercise their professional skill and judgement at all times.

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This is an updated version of the Promoting Refugee Health: A guide for doctors and other health care providers caring for people from refugee backgrounds (2007) and the Caring for Patients in General Practice: a desktop guide (2007) as well as Promoting Refugee Health: A handbook for doctors and other healthcare providers caring for people from refugee backgrounds (2001) and the Refugee Health and General Practice Guide (1998). A web-based version of this Guide, available to download, is provided on on the Victorian Refugee Health Network website: www.refugeehealthnetwork.org.au

Also available on the Foundation House website is a concise desktop summary of this Guide entitled Caring for refugee patients in general practice: A desktop guide.

A Refugee Health Assessment Tool has been developed under the auspices of General Practice Victoria (GPV) to guide GPs in carrying out refugee health assessments. It is available at: www.gpv.org.au

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Using this guide

This guide to caring for people of refugee background can be read as a general background resource or used as a practical guide for specific issues in consultation and management.

New features of the 2012 guide

The updates and changes in this edition of Promoting Refugee Health reflect key developments in the area of refugee health and incorporate the expertise and practice experience of many health providers around the country. Some of the key changes that this Guide addresses are the:

- changing refugee profiles with respect to countries of origin
- changing demographics of refugee communities, particularly the increase in the proportion of children and adolescents
- changes to Australian immigration policies
- changes to settlement service arrangements – in particular the transition from Integrated Humanitarian Settlement Strategy (IHSS) to the Humanitarian Settlement Service (HSS) program
- changes to entitlements (e.g. Centrelink and Medicare) associated with relevant visas
- new Medical Benefits Schedule (MBS) items
- developments to clinical practice
- availability of new resources and updated information
- new sections on women's health, vitamin D and chronic disease.

Kinds of content

Throughout the text particular kinds of content are highlighted in boxes.

KEY POINTS

These provide a summary of major points to consider regarding particular aspects of care for clients from refugee backgrounds.

PRACTICE TIPS

These provide advice and guidance based on the practice experience and knowledge of GPs and other health practitioners working with refugee clients.

RESOURCES

Features select resources on particular aspects of care and provides information and weblinks.

“”

These are personal quotes from refugee clients or health professionals about their experiences of the health care system in Australia.

References

References are listed at the end of each section.

Terminology

In this guide the terms ‘refugee’, ‘survivor’ and ‘new arrival’ are used interchangeably and should be taken, unless otherwise indicated, to include clients with ‘refugee-like’ experiences. Where reference is made to specific categories of entrants within this broader group, this will be clearly indicated in the text. The term ‘survivor’ (rather than ‘victim’) is commonly used when describing people from refugee backgrounds to emphasise their strength and resilience and to promote acknowledgment of their capacity to overcome the disempowering impact of torture and trauma.

Foreword



The way a society looks after its most vulnerable groups is a sign of its maturity and compassion. Refugees, particularly those who are recently arrived, and who have often suffered so much before they have reached Australia, are among the most vulnerable people in Australia. And as a signatory to the United Nations Convention on Refugees, Australia has a long-standing commitment to assisting people fleeing war and persecution.

So how we collectively respond, organise, support and act to promote the health of refugees shows what sort of a society we are and how well we fulfill our obligations as global citizens.

Promoting Refugee Health is a valuable window into both organisation and action. The third edition of this Guide is built on decades of experience, has been revised, updated and expanded and will no doubt become essential reading for anyone involved in caring for refugees or asylum seekers. Promoting Refugee Health is also the only Australian-focused health resource for caring for refugee clients.

Around 13,750 people of refugee background are currently settled in Australia each year through the Humanitarian program. In addition there are significant numbers of asylum seekers living in the community at any given time. Newly arriving refugees and asylum seekers are settling in every Australian state and territory, and increasingly in regional and outer metropolitan areas.

The significant impact of violence, trauma and torture on people's health and wellbeing, together with the sometimes complex and unfamiliar physical health conditions, requires an informed and skilled health workforce. This guide is an important contribution to enhancing those skills of our workforce.

The Guide is an excellent resource for health care professionals including GPs, refugee health nurses, maternal and child health nurses, women's health nurses, school nurses, physiotherapists, dentists, psychologists, social workers, youth workers, dietitians and other health practitioners working in a variety of settings.

It is also an excellent resource for front of house staff and receptionists who often are the first, welcoming contact that refugees have with health services and who are so vital in coordinating communication between service providers.

It is a remarkably comprehensive guide, clearly and cogently structured with a wonderful array of resources, practice tips, summaries of key points and highly instructive quotations from refugees themselves. The addition of a framework for a transition to mainstream services over 10 years assists health care providers to orient care over the longer term. The guide includes clinical information on physical and mental health, cross-cultural communication as well as local referral details for health service providers that have expertise in refugee healthcare.

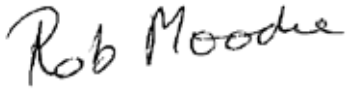
I particularly like the short section on Sensitive health care as a healing process, which explains how health care can, of itself, make a significant contribution to a person's psychological recovery and resettlement in Australia by re-establishing dignity, self-esteem and self-respect. This is indeed true for the whole of our health care system.

Optimal health is a vital resource for successful resettlement. It assists people to cope with the stressors of finding housing, education and employment and also the adjustments involved in learning a new language, culture and way of life.

It is important to acknowledge the valuable role of many health professionals from around the country, who have offered their expertise and practice experience in contributing to this resource.

The publication of this third edition builds on their knowledge and commitment and is a timely contribution to other national, state and territory initiatives and program developments that support the health and wellbeing of refugees.

I would like to acknowledge and thank all the contributors to this excellent guide, and in particular acknowledge the work of the Victorian Foundation for Survivors of Torture, the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT), and the members of the Victorian Refugee Health Network and the Refugee Health Network of Australia (RHeaNA), not only for their ground breaking work over decades, but for the ways they have helped to make Australia a much more compassionate and welcoming society than we otherwise might have been.



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A special thanks to the many other contributors to this guide who are too numerous to name individually but have provided valuable support and expertise to this guide.

An extra special thanks to everyone who contributed to previous editions of this guide. Your contributions have made this update possible and have ensured that this remains a quality resource.

How to navigate this online Guide

There are several ways you can navigate through the Guide's pages.

1. via Bookmarks

Bookmarks are a list of the Guide's Section headings and subheadings and they appear in the bookmarks pane to the left of the page window in your browser.

If this pane is not currently displayed then go to your menu bar and choose View > Navigation Tabs > Bookmarks

You can click each bookmark to move to that page in the Guide. One of the advantages to using bookmarks is that the bookmark pane can always be visible next to the page being read. Also, bookmarks can be expanded or collapsed to shorten the length of the bookmark list. To do this, click on the small plus or minus that appears next to the Section heading in the bookmark pane. This will show or hide the Section's subheadings on your bookmark pane

2. via Hyperlinks

There are two kinds of hyperlinks.

- Those that, when clicked, take you to another page of the Guide. These are displayed most often like this "See [name of section]". The listing of Section headings and subheadings in Contents pages are also set up as hyperlinks allowing you to go straight to individual Section headings or subheadings.
- Those that, when clicked, take you to a website in a new window. These are displayed like this www.[website name].

3. via the page header

On any given page of this Guide, the reader can click on the Promoting Refugee Health page header to return to the first Contents page.

Clicking on the Section title at the top of the page (i.e. Why focus on refugee health?) will take the reader to the Contents page for that Section.

4. via the Back/Forward arrows

At the top of your browser window click:

- the [ ] button to move to the next page
- the [ ] button to move to the previous page.

5. via the scroll bar

Click in the scroll bar down the right side of the browser window to move forward or back through the Guide. This is a less accurate way of moving through the pages.

How to print this Guide

The pages of the Guide are A5 size "landscape" format (width greater than height). If you want to save paper when printing to your A4 laserprinter then choose "2 pages per sheet".

Section 1:
Why focus on refugee health?







The refugee experience has diverse impacts on the health of individuals and families. While health issues affecting individual new arrivals, and particular refugee communities, clearly vary depending on region of origin and the nature and duration of the refugee experience, there are common health concerns across communities. These are extensively documented in Section 4 and Section 5, which look at the particular health concerns of refugee adults, young people and children. It is not unusual for new arrivals to have multiple and complex health problems on their arrival in Australia.[1, 2]

Many clients of refugee background will have experienced interrupted access to health care prior to arriving in Australia. This may be due to the breakdown of health services in situations of war and conflict; constraints on their access to health services in the context of human rights abuses; or limited access to health care in countries of first asylum. Refugee-producing countries often have poorly developed healthcare infrastructure and have a limited capacity to treat those with acute health concerns, let alone offer the illness prevention and mental health support programs now well established in Australia.[3]

As a result, people from refugee backgrounds may have injuries, diseases and conditions (some sustained or acquired as a consequence of deprivation and trauma) that have been poorly managed in the past. They are also likely to have had limited or disrupted access to mental health support or to illness prevention programs such as immunisation.[4]

This does not mean that people from refugee backgrounds are inherently less healthy than the Australian-born population or migrants. Indeed, the fact that they have survived horrific experiences yet ultimately settle very successfully in Australia is evidence of their resilience and survival strengths.

The relatively poor health status of people from refugee backgrounds is testimony to the negative health effects of the refugee experience, with most health problems being due largely to physical and psychological trauma, deprivation of basic resources required for good health, and poor access to health care prior to arrival. Most of these problems can be addressed by sensitive, intensive ‘catch-up’ care, early identification and prevention of disease as well as support in the early period of settlement.

Refugees and asylum seekers in Australia

While the focus of this guide is on the recently arrived refugee client, much of its content is applicable to refugee clients regardless of their time of arrival.

A refugee is defined in the United Nations (UN) 1951 Convention Relating to the Status of Refugees (one of a series of conventions and treaties designed to regulate the rights of refugees internationally) as someone who has left his or her country and cannot return to it owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.[5]

The Australian Government accepts approximately 13,750 people from refugee backgrounds annually through its Humanitarian Program. This is in addition to a larger migration program, which may include people from refugee-like backgrounds. Legislation and programmatic responses to refugees and asylum seekers are subject to change. The Humanitarian Program currently comprises two parts: the offshore and onshore components.[6]

The offshore component

The offshore component comprises people who have been identified (often with the assistance of the United Nations High Commissioner for Refugees) as in need of permanent resettlement. This includes two categories:

- **REFUGEES:** These are people formally defined as refugees under the 1951 UN Convention, sometimes known as 'convention refugees'. The refugee category includes entrants under the Women at Risk Program, a special category introduced in 1989 in recognition of the particular vulnerability of refugee women and including, among others, single parents, widows and abandoned single women.
- **SPECIAL HUMANITARIAN PROGRAM ENTRANTS**: These are people who have experienced substantial discrimination amounting to gross violation of their human rights, and who have strong support from an Australian citizen, resident or community group.[7]

People selected for entry through the offshore component are granted permanent residence in Australia and are entitled to the same benefits and services as Australian nationals as well as some additional assistance in the early settlement period. See Section 9 > Entitlements.

The onshore component[8]

The onshore component is established for people who have entered Australia and who subsequently apply for the protection of the Australian Government under the provisions of the UN Convention. These individuals are referred to as asylum seekers while their claims are considered.

AUTHORISED ARRIVALS

Many asylum seekers enter Australia by plane with valid entry documentation (e.g. on a student or tourist visa). While their application for protection is considered, these people are allowed to reside in the general community on a Bridging Visa. During this time, however, they face limitations on their access to benefits and services.

Subject to being found to be refugees under the terms of the UN Convention and satisfying certain health and character checks, people in these circumstances are granted a Refugee Protection Visa (an 866 Visa), which accords them permanent residence in Australia and its associated rights and responsibilities.

UNAUTHORISED ARRIVALS

Those entering by sea (and occasionally those entering by plane) without valid entry documentation are subject to a period of mandatory administrative detention in an Immigration Detention Facility or an Alternative Place of Detention (APOD). The period of detention varies according to the time taken to finalise all relevant checks, including health, character and document checks. Periods in detention of up to and exceeding 12 months have not been uncommon, and in some circumstances people will have been in more than one detention environment.

Some of those who have been in Immigration Detention Facilities are moved into the Community Detention program (especially families and unaccompanied minors). Case work and related support for this group is provided by the Red Cross and other agencies.

As of late 2011 asylum seekers may be released into the community from detention facilities on a Bridging Visa which affords work rights and access to Medicare. These asylum seekers are not eligible for most other benefits and services.

For information on entitlements for refugees and asylum seekers see Section 9 > Entitlements (p.296).

Asylum seekers have particular healthcare needs stemming from the refugee determination process, limitations on their access to important settlement resources and, in the case of unauthorised arrivals, the effects of incarceration and prolonged uncertainty regarding their residency status. These factors are discussed in greater detail in Section 6 (p.227) and Section 9 (p.293).

RESOURCE

For a full list of refugee and humanitarian visa numbers, visit the Australian Government Department of Immigration's Visa, Immigration and Refugees web portal www.immi.gov.au/visas/humanitarian.

Eligible visa numbers for the MBS refugee health assessment

A number of offshore visas from the refugee and special humanitarian streams, as well as onshore visa recipients are eligible for the Medicare Benefits Scheme (MBS) 'refugee health assessment'. The assessment can be claimed under MBS Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged). Visa numbers eligible at the time of publishing (March 2012) are listed on the MBS website: www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1.

Approaches to the refugee health assessment are detailed in Section 6.

Changing composition of humanitarian intake

Australia's Humanitarian Program is constantly changing in response to refugee crises and resettlement needs internationally. For example, people of African background made up 25% of the total offshore Humanitarian Program in 2001. By 2005 they constituted 70% of the total program. In 2008 the total number of people coming from African nations was around 30% of the entire program, while 35% were from the Middle East and another 33% from Asia.[9] In 2010 the majority of new arrivals came from Asia (33.6%) with a further 31.8% of new arrivals coming from the Middle East and SW Asia, 29.2% from Africa and 0.1-0.3% from the Americas and Europe respectively.

Tables 1.1 and Figure 1.1 show the changing composition of refugees and humanitarian entrants over the last 10 years.

TABLE 1.1 Offshore grants by region from 1998-99 to 2009-10

1998-99	Europe 49.7%	M.E. and S.Asia 30.6%	Africa 16.3%	Asia 3.1%
1999-00	Europe 45.6%	M.E. and S.Asia 29.8%	Africa 22.7%	Asia 1.6%
2000-01	Europe 43.3%	M.E. and S.Asia 27.0%	Africa 25.4%	Asia 4.0%
2001-02	Africa 33.1%	M.E. and S.Asia 32.4%	Europe 32%	Asia 2.2%
2002-03	Africa 48.3%	M.E. and S.Asia 39.9%	Europe 9.9%	Asia 1.8%
2003-04	Africa 70.8%	M.E. and S.Asia 24.3%	Europe 3.0%	Asia 1.9%
2004-05	Africa 70.1%	M.E. and S.Asia 26.2%	Asia 3.4%	Europe 0.2%
2005-06	Africa 55.7%	M.E. and S.Asia 34.0%	Asia 9.9%	Europe 0.4%
2006-07	Africa 50.9%	M.E. and S.Asia 28.0%	Asia 20.7%	Europe 0.4%
2007-08	M.E. and S.Asia 35.3%	Asia 33.7%	Africa 30.5%	Europe 0.6%
2008-09	M.E. and S.Asia 33.5%	Africa 33.2%	Asia 33.1%	Europe 0.1%
2009-10	Asia 38.6%	M.E. and S.Asia 31.8%	Africa 29.2%	Europe 0.3%

M.E. Middle East. S.Asia South Asia

Department of Immigration and Citizenship (DIAC) (2011). Refugee and Humanitarian Issues: Australia's Response. Canberra: Commonwealth of Australia. p.44.

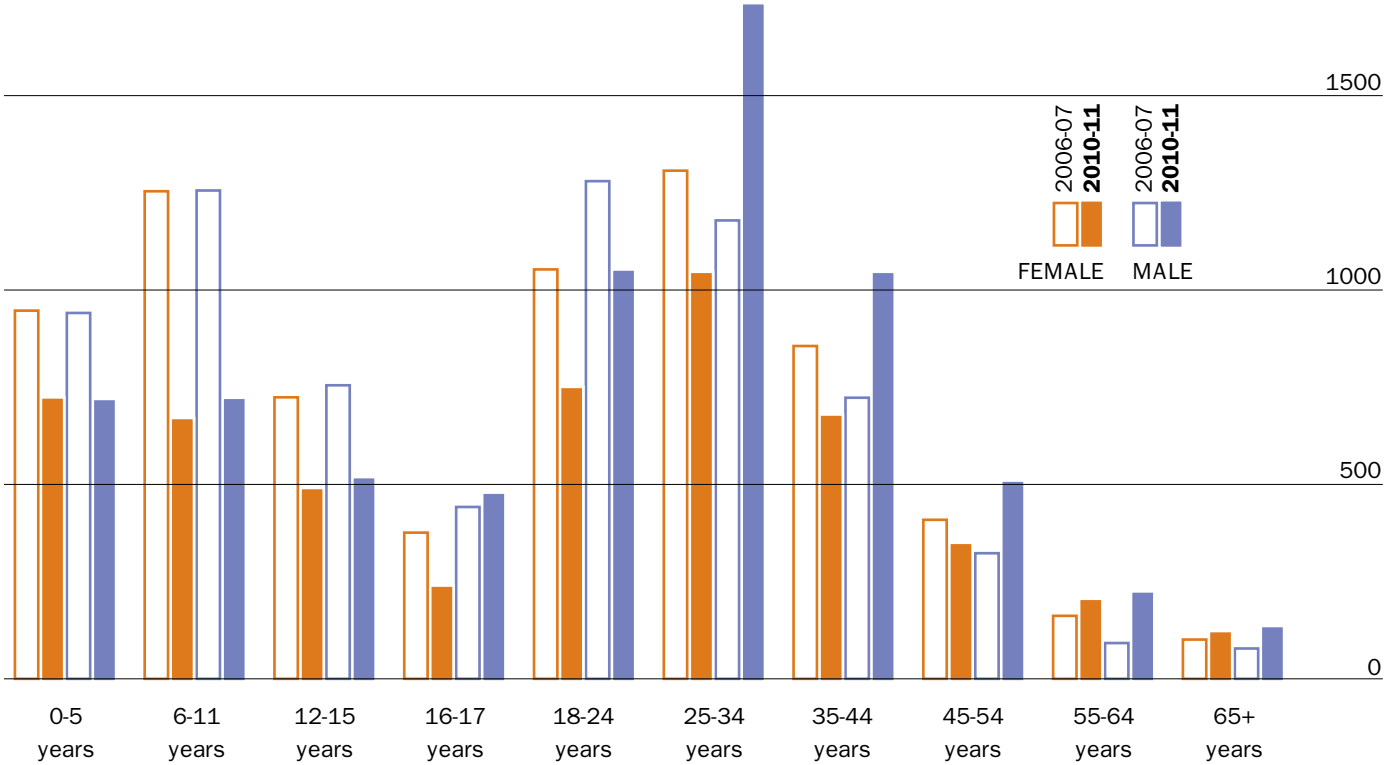
TABLE 1.2 Top 10 countries of birth for humanitarian program 2006-2011

Top ten countries of birth* and number of offshore program arrivals per year

	2006-07		2007-08		2008-09		2009-10		2010-11	
1.	Sudan	2,349	Burma	1,988	**Iraq**	3,609	**Iraq**	2,188	**Iraq**	2,697
2.	**Iraq**	1,826	**Iraq**	1,896	Burma	2,012	Afghanistan	2,079	Afghanistan	2,256
3.	Afghanistan	1,556	Afghanistan	1,015	Afghanistan	1,052	Burma	1,583	Iran	1,213
4.	Burma	1,492	Sudan	821	Thailand	693	Iran	690	Burma	998
5.	DRC	547	Thailand	655	Sudan	674	**Sri Lanka**	670	**Bhutan**	747
6.	Liberia	547	Iran	572	**Sri Lanka**	589	Thailand	566	**Sri Lanka**	512
7.	Iran	544	China	537	Iran	587	**Bhutan**	561	DRC	383
8.	**Sierra Leone**	507	DRC	471	**Bhutan**	573	DRC	551	Nepal	377
9.	Thailand^	477	**Sri Lanka**	454	Ethiopia	402	Ethiopia	428	**Pakistan**	347
10.	**Burundi**	439	**Sierra Leone**	254	China	395	Somalia	383	Thailand	323
	OTHER	3,982	OTHER	3,287	OTHER	3,939	OTHER	4,463	OTHER	2,940
	TOTAL	14,283	TOTAL	11,950	TOTAL	14,525	TOTAL	14,162	TOTAL	12,793

*Country of birth does not indicate ethnicity. Thailand may refer to a child born of Karen, Burmese, Rohingya, Mon or Kachin parents in a refugee camp in Thailand.
DRC — Democratic Republic of the Congo

FIGURE 1.1 **Age and gender of humanitarian entrants: a comparison of 2006 and 2011**



Detailed information on each of the diverse refugee communities in Australia can be found at the links provided in Section 10.

The general information contained in this guide is applicable to working with refugee clients regardless of their country of origin.

Other migration programs

People with 'refugee-like' experiences may also enter through other Australian migration programs (e.g. the Family and Business Migration programs). In many cases these entrants have been sponsored by relatives who themselves entered Australia through the Humanitarian Program and originate from very similar circumstances. It is estimated that one in every eight of the 32,000 entrants settling through the Family Migration Program in the year 2000 came from countries from which Australia accepted refugees.[10, 11]

RESOURCES

DIAC: SETTLEMENT REPORTING FACILITY

This online reporting facility allows users to access DIAC statistical data (on permanent arrivals to Australia since January 1991) in order to produce customised reports. The facility is easy to use and is helpful if you would like to generate reports on the composition of refugee communities in your state or region. Access the Integrated the Settlement Reporting Facility here: www.immi.gov.au/living-in-australia/delivering-assistance/settlement-reporting-facility.

How can a refugee client be identified?

Being able to identify people from refugee backgrounds among other service users from culturally diverse communities is important, enabling health professionals to orient care to their particular needs.

There are two main ways in which a client can be identified as coming from a refugee background. The first is by the visa number. The second way is by the country of origin and/or country of transit. Often this information will be provided on referral.

One of the visa numbers listed in Table 9.1 (p.296) will indicate a person who has a refugee background. However, people who have come to Australia under another migration program may also have a refugee background. They need to be identified by their country of origin. For example, if someone comes from Somalia they may arrive under another migration program but they will almost certainly have a refugee background.

People who have been in Australia for some time may not want to identify themselves as refugees or want to present visa number details. If the country of origin is one that has a history of conflict and human rights violations, e.g. Sudan or Burma, the client is likely to be of refugee background. The country of transit, for example Kenya, Pakistan, Egypt, Thailand or Malaysia, can also suggest a refugee background.

There are a number of other countries indicating possible refugee background. If the time of arrival corresponds with a period of conflict in the country of origin, a stronger likelihood of refugee background is indicated. For example, someone from Lebanon who arrived at the time of civil conflict in the 1980s may have come as a refugee.

Special health concerns of refugees

Physical health and prior access to health care

Most of the world's refugees originate from countries where basic resources required for health, such as safe drinking water, shelter, an adequate food supply and education, are scarce.[12] In many of these countries, diseases and conditions, now rare in more affluent societies through appropriate physical planning and social support measures, are commonplace. This also applies to many of the countries in which people may have spent a period of asylum before being offered permanent settlement in Australia. Already struggling to meet the needs of their citizen populations, these countries have a limited capacity to meet the needs of those seeking refuge within their borders.

Many refugee clients have had poor access to health care prior to arriving in Australia. This may be due to the breakdown of health services in situations of war and conflict; constraints on their access to health services in the context of human rights abuses; or limited access to health care in countries of first asylum. Refugee-producing countries often have poorly developed healthcare infrastructure, the consequence of low levels of economic development and the compounding effects of war and natural disaster.[13] These countries have a limited capacity to treat those with acute health concerns, let alone offer the illness prevention and mental health support programs now well established in Australia.

As a result, people from refugee backgrounds may have diseases and conditions (some sustained or acquired as a consequence of deprivation and trauma) that have been poorly managed in the past. They are also likely to have had limited or disrupted access to mental health support or to illness prevention programs such as immunisation.

Trauma and torture

By virtue of the means by which they have gained entry to Australia, people from refugee backgrounds will almost certainly have been exposed to traumatic events such as prolonged periods of deprivation, human rights abuses, the loss of loved ones or a perilous escape from their homelands. In addition, a significant proportion will have been subject to severe physical and/or psychological torture. There is now a large body of evidence indicating that this exposure may have long-term physical[14, 15] and psychological sequelae.[16, 17] High rates of post-traumatic stress disorder (PTSD) symptoms, the result of exposure to horrific, life-threatening events, are well documented in refugee populations.[18] Prolonged deprivation; limited social and family support; the loss of place, identity and culture; and separation from, or loss of family members also have an impact on mental wellbeing. This contributes to a relatively high prevalence of depression, guilt, anxiety and grief among survivors.[19]

For more detailed information on the impact of torture and trauma, see Section 3 (p.45).

The impact of resettlement on health

While people from refugee backgrounds are often in relatively poor health on arrival in Australia, the early settlement period may be one during which they are exposed to further negative influences on their wellbeing. Many may experience ongoing grief associated with the loss of family and friends, culture and community. Anxiety is a common consequence for those facing continuing uncertainty about the fate of family members left behind. People who have survived horrific experiences may also have a profound sense of guilt, particularly if family and friends were lost to conflict or remain in difficult circumstances in their countries of origin or first asylum.

Settling in a new country involves enormous adjustments. These include learning a new culture and way of life and gaining mastery over a host of practical tasks, from acquiring a new language and using public transport to negotiating new and complex education, income support and health systems. These adjustments may be experienced as overwhelming for some people, in particular those from rural or pastoral communities settling in highly urbanised environments.[20] For those exposed to severe trauma, some of the tasks of settlement (such as dealing with people in authority) may serve as painful reminders of past experiences, exacerbating existing psychological problems.

A strong body of evidence from studies internationally show that the health of both individuals and communities is influenced by their access to social and economic resources. As well as assets such as housing, education, employment and income, these include less tangible resources such as social connection and support, a social position with meaning and value, and freedom from discrimination and violence. In general those with limited access to these resources have poorer physical and mental health than those whose access is good.[21]

The early settlement period may be a time when people from refugee backgrounds have limited access to resources known to protect and promote health. They tend to be over-represented among the poor and to experience associated social and economic disadvantage[22]; are concentrated in those areas of the labour market characterised by poor working conditions and remuneration and job insecurity[23]; experience relatively high rates of both unemployment and underemployment; and are often housed in substandard and insecure accommodation[24, 25]. Lack of understanding, and in some cases active discrimination and racism in the host community, can further serve to undermine their sense of physical security and self-esteem.[26] This is particularly the case for the current intake of refugee migration, which is occurring amidst a controversial debate about Australia's response to refugees and asylum seekers. It is also a time when there is limited demand for labour and constraints on other resources required for successful settlement (e.g. housing, education and training). Community and government responses to the 'refugee problem' may make for a less receptive social climate than that experienced by those coming to Australia through earlier waves of migration.

The early settlement period is also a time when people may have limited access to the protective effects of family and social support. While many will have lost or become separated from family members in the course of their refugee experiences, cultural and language differences may make it difficult for them to establish connections and secure social support within the receiving society.

For more information on early settlement issues and entitlements see Section 9 > Entitlements (p.293).

Access to health care

On arrival in Australia, people from refugee backgrounds may experience difficulties in accessing and making the best use of health services. Negotiating a new and unfamiliar health system may be a complex undertaking, particularly for those with multiple health needs requiring numerous investigations and follow-up appointments. This can often be compounded by cultural and language differences between new arrivals and healthcare providers. Many new arrivals will be unfamiliar with illness prevention approaches and may be unaccustomed to the culture that characterises relationships between healthcare users and providers in Australian (e.g. the emphasis on choice and informed consent).

Some may find it difficult to prioritise health concerns in the context of other settlement tasks, many of which are central to their survival in Australia (e.g. finding housing and employment). Moreover, sub-optimal health may be something they have learned to live within the context of prolonged deprivation.

Health consultation may be a particular source of anxiety, especially if it involves physical examination, invasive procedures or detailed history-taking. As a consequence of experiences in their country of origin, many refugee clients may have a mistrust of authority figures, among them medical professionals. For some this fear is well founded, with doctors having been actively involved in perpetrating or supervising torture in a number of repressive regimes.[27] Psychological sequelae associated with trauma and torture (e.g. depression and guilt) may also undermine motivation for the self-care required to access and participate in health care.

For further information, see Section 3 (p.45) and Section 8 (p.281).

The importance of health as a resource for successful resettlement

Optimal health is an important resource for people from refugee backgrounds, assisting them to deal with the practical and emotional demands of settling in Australia. Poor health, however, can serve as a significant barrier to settlement. For example, post-traumatic stress disorder (PTSD) symptoms, such as poor concentration, may interfere with the important task of learning English. Similarly, chronic pain, a common consequence of torture and war-related injury, may affect the ability to perform the day-to-day organisational tasks of settlement.

The importance of early identification

Large-scale studies have indicated that in many areas of physical and mental health there are significant advantages both to the individual and the 'public purse' of identifying and treating health problems at an early stage. At this stage problems are generally less costly and complex to treat.[28] A proactive early intervention approach is particularly important for new arrivals given their relatively poor health status, their limited access to health care in the past and the barriers they may face in seeking care following their arrival.

Further, some health problems experienced by people from refugee backgrounds (e.g. parasitic infection and some nutritional deficiencies) are asymptomatic and therefore unlikely to be identified by new arrivals themselves.

The early settlement period also provides a window of opportunity to not only introduce new arrivals to specific treatment and illness prevention services, but to assist them in establishing a positive understanding of, and relationship with, the healthcare system.

For more information see Section 4 > Health concerns of adult refugee clients (p.79) and Section 5 > Child and adolescent health (p.177).

Sensitive healthcare as a healing process

As well as having obvious benefits for addressing physical and mental health problems, health care can of itself make a significant contribution to a person's psychological recovery. In the context of a sensitive and caring relationship with a person from a refugee background, Australian healthcare professionals can:

- provide reassurance to those who fear that they have been irreparably harmed by their experiences
- contribute to re-establishing dignity, self-respect and self-esteem
- communicate to people that they are worthy of care, thereby affirming the importance of self-care
- help to re-establish trust and confidence in figures of authority.

The role of Australian health care professionals

In the early settlement period, new arrivals may have contact with a range of health professionals, among them doctors, refugee health nurses, maternal and child health nurses, women's health nurses, school nurses, physiotherapists, dentists, psychologists, social workers, youth workers, dietitians and others in community health settings.

As well as providing direct clinical care, many of these professionals may also be in a position to provide support and information to assist people to access health care and other settlement resources. While the nature and extent of their contribution will depend on their professional roles and the settings in which they work, they can support people from refugee backgrounds to attain good health by:

- offering or arranging thorough medical examination and follow-up care
- using interpreters to optimise communication, build rapport and reduce anxiety
- supporting people to address practical barriers to accessing health care

- being sensitive to the effects of trauma and torture, cultural differences and different experiences of using health services on consultation
- providing information on the healthcare system and healthcare services available in Australia
- offering or supporting people to access psychological support where required
- linking people with the services, resources and networks required for successful settlement.

References

1. Ngeow, J., Skull, S., & Biggs, B. (2000). 'Assessment of the health and vaccination status of recently arrived immigrants in Australia: African Community Health Project Victorian Infectious Diseases Service and the Department of Medicine, University of Melbourne'. Unpublished paper.
2. Paxton, G., Smith, N., Ko Win, A., Mulholland, N., & Hood, S., (2011). Refugee Status Report: A Report on How Refugee Children and Young People in Victoria are Faring. East Melbourne: State of Victoria, Department of Education and Early Childhood Development.
3. Henderson, S., & Kendall, E. (2011). 'Culturally and linguistically diverse peoples' knowledge of accessibility and utilization of health services: Exploring the need for improvement in health service delivery'. Australian Journal of Primary Health, 17, 195-201.
4. Paxton, G.A., Rice, J., Davie, G., Carapetis, J.R., & Skull, S.A. (2011). 'East African immigrant children in Australia have poor immunization coverage'. Journal of Paediatrics and Child Health, 47, 888-892.
5. UN General Assembly (1951). Convention Relating to the Status of Refugees. 28 July 1951, United Nations, Treaty Series, vol. 189. Retrieved from < www.unhcr.org/refworld/docid/3be01b964.html >.
6. Department of Immigration and Citizenship (DIAC) (2011). Refugee and Humanitarian Issues: Australia's Response. Canberra: Commonwealth of Australia.
7. DIAC (2011). Fact Sheet 60: Australia's Refugee and Humanitarian Program. Canberra: Commonwealth of Australia. Retrieved from < www.immi.gov.au/media/fact-sheets/60refugee.htm >.
8. DIAC (2011). Fact Sheet 65: Onshore Processing Arrangements for Irregular Maritime Arrivals. Canberra: Commonwealth of Australia. Retrieved from < www.immi.gov.au/media/fact-sheets/65onshore-processing-irregular-maritime-arrivals.htm >.

9. DIAC (2009). Refugee and Humanitarian Issues: Australia's Response. Retrieved from < www.immi.gov.au/media/publications/refugee/ref-hum-issues/pdf/refugee-humanitarian-issues-june09.pdf >.
10. Department of Immigration and Multicultural Affairs (2000). Population Flows: Immigration Aspects 2000 Edn. Canberra: Commonwealth of Australia.
11. NSW Health (1999). Strategic Directions in Refugee Health Care in NSW. Sydney: NSW Health Department.
12. United Nations Development Program (UNDP) (2006). Human Development Report 2006: Beyond Scarcity: Power, Poverty and the Global Water Crisis, UNDP Retrieved from < hdr.undp.org/hdr2006 >.
13. US Committee for Refugees and Immigrants (USCRI) (2009). World Refugee Survey 2009. Retrieved from < www.refugees.org/resources/refugee-warehousing/archived-world-refugee-surveys/2009-world-refugee-survey.html >.
14. Skylv, G. (1992). 'The physical sequelae of torture'. In M. Basoglu (Ed.), Torture and its Consequences: Current Treatment Approaches. Glasgow: Cambridge University Press.
15. Pagaduan-Lopez, J.C. (1987). Torture Survivors: What Can We Do for Them? Manila: Medical Action Group Inc. 9-11.
16. Parker, M. (1996). 'The mental health of war-damaged populations'. IDS Bulletin, 27(3).
17. Somnier, F., Vesti, P., Kastrup, M., & Genefke I. (1992). 'Psycho-social consequences of torture: Current knowledge and evidence'. In M. Basoglu (Ed.), op cit.
18. Baker, R. (1992). 'Psychosocial consequences of tortured refugees seeking asylum and refugee status in Europe'. In M. Basoglu (Ed.), op cit.
19. Victorian Foundation for Survivors of Torture (VFST) (1998). Rebuilding Shattered Lives. Melbourne: Victorian Foundation for Survivors of Torture.
20. Lin, K. (1986). 'Psychopathology and social disruption in refugees'. In L. Williams, & J. Westermeyer (Eds.). Refugee Mental Health in Settlement Countries. New York: Hampshire Publishing.
21. Victorian Health Promotion Foundation (2000). Mental Health Promotion Plan 1999-2002: Foundation Document. Melbourne: Victorian Health Promotion Foundation.
22. Saunders, P. (1998). 'The immigrant poverty profile'. Migration Action, 20(3).
23. Watson, I. (1998). 'Long-term unemployment and NESB immigrants'. Migration Action, 20(3).
24. Couch, J. (2011). 'My life just went zig zag: Refugee young people and homelessness'. Youth Studies Australia, 30 (2), 22-32.
25. Foley, P., & Beer, A. (2003) Housing Need and Provision for Recently Arrived Refugees in Australia. Australian Housing and Urban Research Institute: Southern Research Centre.
26. Medical Faculties of the Universities of Copenhagen, Odense and Aarhus and the Danish National Board of Health (1990). 'Medical involvement in the practice of torture'. In medical aspects of torture'. Danish Medical Bulletin, 37(1), 1-88.
27. Amnesty International French Medical Commission, & Marange, V. (1989). Doctors and Torture: Resistance or Collaboration? London: Bellew Publishing.
28. Australian Government Department of Health and Aged Care (1999). Mental Health Promotion and Prevention: National Action Plan, National Mental Health Working Group and the National Public Health Partnership. Canberra: Commonwealth of Australia.

Section 2:
Cross-cultural communication





Communication with a client from a refugee background may be affected by language and cultural differences as well as different social, economic and political experiences.

The importance of using a professional interpreter

It is particularly important that a professional interpreter is offered to the refugee client for the following reasons.

- There are ethical and safety issues[1, 2, 3, 4] associated with using a family member, friend, bilingual employee, or untrained person to interpret. For example:
  - health professionals have no certainty of information provided to clients, which could lead to a significant risk of misdiagnosis and/or mistreatment
  - untrained interpreters are unlikely to know medical terms in both languages
  - clients may feel embarrassed when talking about sensitive matters in the presence of family members, bilingual workers or community members
  - use of a non-professional interpreter may place undue stress on relationships within the family, and in the case of children, may impose an unfair burden of responsibility on them
  - the untrained interpreter may be exposed to information of a sensitive or traumatic nature.
- Professional interpreters are trained in the use of English and a second language and in appropriate communication skills. They are bound by a professional code of ethics, which places great emphasis on confidentiality. Confidentiality is crucial in working with refugee clients. The National Accreditation Authority for Translators and Interpreters (NAATI) is the body responsible for setting and monitoring the standards for the translating and interpreting profession in Australia.
- A client who has only recently arrived in Australia is unlikely to have acquired even rudimentary English or to have commenced the process of acculturation to a new society, with the result that the potential for misunderstanding is great.
- It improves both the quality and safety of the provision of health care.

- Clients are generally more confident when professional interpreters are used.
- Healthcare professionals have a professional obligation to understand their clients' needs.
- Clients have a right to understand the information provided by their healthcare professionals and any follow-up recommendations.
- Use of interpreters forms part of the Royal Australian College of General Practitioners Standards for General Practices (4th edn), which are a part of the accreditation process for general practice clinics in Australia (AGPAL).

"When I had a caesarean I did not have an interpreter. I was by myself in the room with the doctors and nurses. I would have liked one there, especially to explain all the anaesthetics things and what was going to happen, actually for many things".[5]

Consider offering an interpreter even to those clients who appear to have some command of English for the following reasons.

- The anxiety associated with health consultation may interfere with their command of a second language.
- Refugee clients may lack the range of vocabulary required to communicate accurate diagnostic information (e.g. to distinguish between throbbing or piercing pain).
- Refugee clients may not have acquired the more sophisticated terminology required to communicate about intimate bodily processes without resorting to the vernacular; this may be a source of embarrassment.
- Politeness may lead the client to indicate that they have understood when this is not so.

"The first time I was asked if I wanted an interpreter but I thought because I had a little English I should say no. I did not realise that a lot of information I did not understand and then I felt embarrassed and did not ask for one after that, but it would have been good".[5]

Interpreting services

On-site and telephone interpreting is free for all GPs, specialists and pharmacists in private practice for Medical and Pharmaceutical Benefits Schedule funded services.

The Australian Government, through Translating and Interpreting Service (TIS) National, provides free on-site and telephone interpreting services and document translation when communicating with patients for items claimable under Medicare. GPs, specialists, pharmacists prescribing PBS medications and reception staff working in private practice as well as nurses, radiographers and medical technicians working under instruction of eligible doctors, have free telephone access to interpreters, 24 hours a day, 7 days a week, via the Doctors' Priority Line. The Doctors' Priority Line allows GPs and specialists to jump the call queue for the general TIS service, providing access to interpreters for medical consultations within three minutes.

Booking an interpreter can be streamlined by obtaining a TIS Client Code Number, by completing the form available from The Department of Immigration and Citizenship's TIS page www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm. On-site interpreters are available for appointments on weekdays between 8 am and 6 pm. In extraordinary circumstances, they can be arranged for outside these hours. Ideally, bookings for on-site interpreters should be made three working days in advance by the medical practice. A telephone interpreter can also be booked in advance using the Request for Pre-Booked Telephone Interpreter form available from TIS.

PRACTICE TIP

The Doctors' Priority Line phone number is 1300 131 450 whereas the general TIS National number is 131 450. If you call the 1300 number, you will be taken directly to the front of the queue. You will not usually need to wait more than three minutes to obtain an interpreter on the line. Many GPs have set the Doctors' Priority Line as a speed-dial number so that they can access an interpreter as quickly as possible. Front-of-house staff can also use the Doctors' Priority Line free of charge. If patients call and cannot be understood when making an appointment, obtain their phone number and their preferred language and call them back through the Doctors' Priority Line in order to arrange an appointment.

On-site and telephone interpreters

Community services delivering any of the three Targeted Community Care (Mental Health) Program (TCC) service streams also have free access to TIS National. This includes personal helpers and mentors (PHaMHS); Mental Health Respite; and/or Mental Health Community Based (MHCB) services. It should be noted that at the time of publication (February 2012) psychologists, social workers and occupational therapists charging under the Better Access to Mental Health Care Initiative and allied health professionals charging under Extended Primary Care items do not have access to fee-free interpreting services.

Other interpreting services

State-funded interpreter services or direct interpreter services are available in community health centres and public hospitals. The interpreter service provider may be different in each setting, ensure you understand the booking procedures for the setting in which you work.

Alternative interpreter services may be available on a 'fee-for-service' basis in Australian states and territories. See Section 11 (p.323).

PRACTICE TIP

Ethnologue is an encyclopaedic reference cataloguing the world's known living languages. It is a handy resource for GPs, nurses and front-of-house staff to assist in establishing the preferred language of clients. Ethnologue is available online: www.ethnologue.com/country_index.asp.

RESOURCES

The Doctors' Priority Line (available 24 hours a day, seven days a week): 1300 131 450

Forms to register for a TIS National Client Code: www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm.

Forms to pre-book a telephone interpreter: www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/_pdf/request-pre-booked-telephone-interpreter.pdf.

Doctors' Priority Line three-minute instructional clip at DIAC's ImmiTV site: www.youtube.com/user/ImmiTV#p/c/5/MXy-QF9GHyM.

RACGP Standards for General Practices (4th edn): www.racgp.org.au/standards.

Australian General Practice Accreditation Ltd, Quality in Practice: www.qip.com.au.

The National Accreditation Authority for Translators and Interpreters (NAATI): www.naati.com.au.

KEY POINTS

Arranging an interpreter

- A longer consultation time may be required to allow for the additional time involved in communicating through an interpreter.
- Consider enlisting the cooperation of administrative staff to implement a system for booking interpreters.
- Ensure you have systems in place to allow interpreters to be booked when required, for either face-to-face or telephone interpreting.
- Plan consultations in advance where possible, so that an interpreter can be present and a longer consultation time allowed.
- Establish the client's preferred language. Place of birth and ethnicity are not necessarily reliable indicators of preferred language.
- Ask the client if they prefer a male or female interpreter.
- Always abide by the client's choice of language (and dialect), gender and ethnicity of interpreter.
- Endeavour to book the same interpreter for appointments with the client, as this will help to promote rapport, trust and continuity of care. If the interpreter is not available for an appointment explain this to the client.
- Consider training in the use of interpreters for health practitioners and other staff.

KEY POINTS

Communicating through an interpreter[6, 7]

- Choose seating arrangements that will enable direct communication with the client.
- Introduce yourself to the interpreter. Your relationship with the interpreter is crucial to the client.
- Introduce the interpreter to the client and explain your role and that of the interpreter.
- Maintain eye contact with the client rather than the interpreter.
- Watch for body language clues and address any questions you may have about these to the client.
- Speak in the first person. You are speaking to the client through the interpreter who then speaks to the client.
- Always check that the client has understood what you have said. Avoid relying on the interpreter to give instructions or to simplify information.
- Speak slowly and clearly using one or two sentences at a time. Pause to allow time for interpreting.
- Avoid lengthy conversation with the interpreter in front of the client.

- If communicating through a telephone interpreter, ideally a hands-free speaker phone should be used.
- When establishing a client history, be sensitive to the patient revealing personal information through an interpreter, particularly if the interpreter is a member of their community. If the client feels uncomfortable with a particular interpreter, provide assurance that she/he does not have to proceed and that an alternative interpreter can be requested. If you have concerns about the use of a particular interpreter this may need to be checked with the client using a telephone interpreter at a later date.
- Let the interpreter and client leave together. If necessary, debrief with the interpreter by telephone at a later time.
- Consider the debriefing needs of the interpreter. While debriefing may already be incorporated into the work program of the interpreter, this is not always the case.

RESOURCES

Making the Connection, a CD or DVD training resource available online, presents insights into how best to work with interpreters in a variety of work situations. This and other language resources are available at the Department of Human Services website: www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications/making-the-connection-manual.

TIS National has produced a three-part promotional DVD that is a useful training resource on working with interpreters. It can be viewed in chapters (each chapter is three to five minutes in length) or ordered at the Department of Immigration and Citizenship website: www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/promotional-dvd.htm.

Australian Family Physician dedicated its April 2010 publication to the theme of 'Culture and diversity'. You can view the articles from this volume, including Christine Phillips' 'Using Interpreters – A guide for GPs' at this address: www.racgp.org.au/afp/201101.

The impact of culture and prior experience on health care

Communication with a refugee client may be affected by cultural differences in:

- patterns of communication
- views about the causes of illness
- views about the ways in which illness should be managed
- views about the relationship between service provider and client
- views about the role of Western-style medicine in the management and prevention of illness
- individual versus communal approaches to illness and health
- views about gender roles
- customs and practices.[8]

It is important not to attribute all differences to the impact of culture. There is significant diversity within cultural groups, with health status, health practices and a client's experience of health care being mediated by a range of factors such as gender, education and literacy levels and socioeconomic status and rural or urban background in country of origin. People originating from a rural background will generally be less familiar than their counterparts from large urban centres with the style of medicine practised in Australia.[8]

Prevention of illness can be an unfamiliar concept[9]

"If you don't feel sick, you're healthy."

"She just lives. She does not look into her health by eating well or sleeping. She just worries about sickness if it comes."

"When you are sick, you are sick. That's why you go to the hospital to see the doctor. When you are not sick, you are fine and you are happy and you don't have to come to the hospital."

Reaction to multiple investigations

"There is a problem with having so many check-ups. It causes stress because if the doctor sends you to check up more than three times and they keep saying we don't know what the problem is that will make you suspicious. Maybe they're hiding something or they find something in your body but they don't want to tell you and they want to know more so that's a bit of stress and anxiety."[9]

KEY POINTS

Taking into account the client's cultural beliefs and practices

How can I make sure that I take the client's cultural beliefs and practices into account?

While documenting the specific cultural beliefs and practices of Australia's diverse refugee communities is beyond the scope of this guide, consider the following to promote culturally responsive health care:

- Take opportunities to familiarise yourself with the cultural beliefs and practices of clients with whom you work.
- Acknowledge that you understand the client may have different perspectives and experiences around illness and health.
- Ask clients if there are any special requirements or information they would like you to take into consideration when providing care.
- Avoid making generalisations about an individual client on the basis of your experience of other clients from that cultural or ethnic group, as there is significant diversity within groups.
- Avoid making assumptions based on a client's adherence to cultural or religious practices. For instance, a Muslim woman may wear the traditional veil, but may not be devout in other respects.
- When working with individual clients, check any assumptions you have formed directly, for example, 'I understand that many Muslim women prefer to see a woman doctor ... is that your preference?'
- Beware of attributing too much to culture and ethnicity, particularly as there is a range of factors affecting refugee clients (e.g. trauma and torture, experiences in their country of origin, settlement issues).
- Be aware of the impact of your own culture in relating to clients. Consider your own values, expectations and attitudes and how these may affect the care you give to people from other cultures. For example, your confidence in a Western biomedical approach may lead you to overlook or dismiss alternative health beliefs that may be held by people from other cultures.
- In some cultures, it is common for family members to be involved in decision-making in healthcare matters. Additional time may be required for explanation and discussion.
- If it is your assessment that the client is very unfamiliar with the approach to health care in Australia, consider asking straightforward questions about the client's view of the causes of their health problem, how they feel at present, what they are most afraid of and what they believe will help.

Reactions to blood tests[9]

"You always go there suffering and they just draw a large amount of blood."

"I come for a blood test, I expect to come for one ... not so many, you know."

"What do you do with the remaining blood? Do you pour it out or do you put it somewhere?"

"Back in Sudan, they only take a small amount of blood; blood tests are not well known. In Sudan, they use the blood for other things. They give the blood away or sell it without permission."

KEY POINTS

Strategies for communicating clearly with your client[9]

Cultural differences in communication patterns, anxiety and language may all affect communication between the practitioner and refugee client. Effective communication can be maximised in the following ways:

- Offering an interpreter to clients whose first language is not English.
- Checking that instructions have been understood. This may involve repeating them, if necessary. This is particularly important when prescribing medicines. A client is more likely to comply with a treatment regime if they fully understand how to follow it and, where relevant, how it works.
- Asking the client to repeat instructions to ensure that they have been understood. This is especially important for clients who might be anxious or who may believe that asking questions of a doctor is a sign of disrespect.

KEY POINTS

Encouraging clients to ask questions

Some suggested questions are as follows:

- 'I want to be sure that I explained your medication correctly. Can you tell me how you are going to take this medicine?'
- 'We covered a lot today about your diabetes, and I want to make sure that I explained things clearly. So let's review what we discussed. What are three strategies that will help you control your diabetes?'
- 'What are you going to do when you get home?'

"

"For some of us that have been here a few years we have 'everyday English' and when the nurses speak slowly to us and use their hands we can understand so much more. It is so much better than those who speak very fast or speak about us when we are in the room".[5]

KEY POINTS

Medical and other difficult terminology

- When prescribing, asking the interpreter to write the dose and course instructions in the client's own language.
- Avoid colloquialisms, which may have little meaning for people from other cultures (e.g. 'Are you under the weather today?').
- Give specific instructions that might be considered superfluous when consulting with a longer-term Australian resident. It may not be sufficient to say, 'Now I am going to check your chest'. Rather you may need to ask, 'Could you remove your shirt so that I can listen to your chest?'
- Where the client is literate in their own language, offer them translated material if available.
- Using visual aids (e.g. diagrams, pictures, demonstrations) and audiovisual material.
- Avoid using a raised voice, as this will not enhance communication or increase understanding if language barriers exist.

RESOURCES

NSW Refugee Health Service (2005) Guides for Australian Health Professionals: www.swsahs.nsw.gov.au/areaser/refugeehs/resources_guides.asp.

The EthnoMed (USA) site contains information about cross-cultural care including working with interpreters, cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants, many of whom are refugees fleeing wartorn parts of the world ethnomed.org/clinical/clinical%20pearls.

Australian Family Physician audio program (April 2010) on compassionate listening, cultural competence, the importance of culture and ethnicity in care and the use of interpreter services www.racgp.org.au/afp/audio.

Victorian Transcultural Psychiatry Unit (2006), Guidelines for Working Effectively with Interpreters in Mental Health Settings, July www.vtpu.org.au/docs/interpreter/VTPU_GuidelinesBooklet.pdf.

Consider printing Centre for Culture, Ethnicity and Health Language Services factsheets as a handy practice resource www.ceh.org.au/resources/publications.aspx.

References

1. Bird, S. (2010). 'Failure to use an interpreter'. Australian Family Physician, 39(4), 241-242. Retrieved from < www.racgp.org.au/afp/201004/201004bird.pdf >.
2. Atkin, N. (2008). 'Getting the message across: Professional interpreters in general practice', Australian Family Physician, 37(3), 174-176. Retrieved from < www.racgp.org.au/afp/200803/200803atkin.pdf >.
3. Chen, A. (2006). Doctoring across the language divide. Health Affairs, 25(3), 808-813. doi: 10.1377/hlthaff.25.3.808 Retrieved from < content.healthaffairs.org/content/25/3/808.full.html >.
4. Huang, Y-T. , & Phillips, C. (2009). 'Telephone interpreters in general practice: Bridging the barriers to their use'. Australian Family Physician, 38(6), 443-446. Retrieved from < www.racgp.org.au/afp/200906/200906huang.pdf >.
5. Nicolaou, M. (2011). The Pregnancy and Post Birth Experience of Women from Refugee Backgrounds Living in the Outer East of Melbourne: A Healthy Mothers Healthy Babies Research Report 2011. Melbourne, Victoria, Australia: EACH Social and Community Health. Retrieved from < www.each.com.au/health-promotion/images/uploads/EACH_HMHB_Report_VR5_24-11-11.pdf >.
6. Miletic, T., Piu, M., Minas, H., Stankovska, M., Stolk, Y., & Klimidis, S. (2006). Guidelines for Working Effectively with Interpreters in Mental Health Settings. Melbourne, Victoria, Australia: Victorian Transcultural Psychiatry Unit. Retrieved from < www.vtpu.org.au/docs/interpreter/VTPU_GuidelinesBooklet.pdf >.
7. Phillips, C. (2010). 'Using interpreters: A guide for GPs'. Australian Family Physician, 39(4), 188-195. Retrieved from < www.racgp.org.au/afp/201004/201004phillips.pdf >.
8. Waxler-Morrison, N., Anderson, J. M., Richardson, E., & Chambers, N. A. (2005). Cross Cultural Caring: A Handbook for Health Professionals (2nd edn.). Vancouver, Canada: University of British Colombia Press. Retrieved from < www.ubcpress.ca/books/pdf/chapters/waxmor.pdf >.

9. Walker, K. (2005). I Would Rather They Tell Me: Sudanese Refugees' Experiences of Health Assessment. A Pilot Study. Melbourne, Victoria, Australia: Department of General Practice, Monash University. Retrieved from < www.vtpu.org.au/docs/communityprofiles/sudanese%20refugees%20experiences%20of%20health%20assessments.doc >.

Other reading

Bean, R. (2006). 'The Effectiveness of Cross-cultural Training in the Australian context'. (Report prepared for the Department of Immigration and Multicultural Affairs on behalf of the Joint Commonwealth, State and Territory Research Advisory Committee). Canberra, ACT, Australia: Commonwealth of Australia. Retrieved from < http://www.immi.gov.au/media/publications/research/cross_cultural/ >.

National Health and Medical Research Council (NHMRC). (2006). Cultural competency in health: A Guide for Policy, Partnerships and Participation. Canberra, ACT, Australia: Commonwealth of Australia. Retrieved from < http://www.nhmrc.gov.au/guidelines/publications/hp19-hp26 >.

Pauwels, A. (Ed.). (1991). Cross-cultural Communication in Medical encounters. (Working paper no. 4, Monash University National Centre for Community Languages in the Professions). Melbourne, Victoria, Australia: National Languages Institute of Australia, Monash University.

Renzaho, A. (2008). Re-visioning cultural competence in community health services in Victoria. Australian Health Review, 32(2), 223-235.

Section 3:
Trauma and torture experiences — psychological and physical sequelae, management and psychological approaches



Knowledge about trauma and torture and its physical and psychological sequelae is important for several reasons. Namely:

- **such information is integral to assessment and diagnosis, and planning treatment and follow-up**
- **a client's trauma and torture history may have an impact on a health professional's capacity to elicit accurate information for assessment, diagnosis and follow-up care and treatment**
- **special care needs to be taken, as a health consultation may be a source of anxiety for a traumatised client**
- **psychological recovery is assisted by attention to a client's particular needs, referrals for counselling and other forms of specialised care**
- **where suitable, a health practitioner can provide direct psychological support, counselling and other treatment.**

Traumatic events characteristic of the refugee experience

People from refugee backgrounds will almost certainly have been exposed to traumatic events. These may have included:[1, 2, 3]

- threats to their own lives or those of their family or friends
- death squads
- witnessing of mass murder and other cruelties inflicted on family or other people
- disappearances of family members and friends
- perilous flight or escape
- separation from family members
- forced marches
- extreme deprivation: poverty, unsanitary conditions, lack of access to health care
- persistent and long-term political repression, deprivation of human rights and harassment
- removal of shelter, forced displacement from their homes
- refugee camp experiences involving prolonged squalor, malnutrition and a lack of personal protection
- privation of personal space with consequent disruption to personal and intimate relationships
- interrupted or lack of education.

While the prevalence of torture is unknown, health professionals and researchers often estimate that up to 35% of the world's refugee population have had at least one experience of torture.[4]

It is important to know that experiences of torture vary. The United Nations High Commissioner for Refugees (UNHCR) estimates that 80% of refugee women have experienced some kind of sexual abuse or torture. The high incidence of rape East African women refugees is now well documented,[5, 6, 7] as is the systematic use of rape by the Burmese military.[8, 9]

Exposure to trauma and torture is not confined to adults. Many child refugees have witnessed horrific events and have suffered the effects of dislocation and deprivation. In some regimes, children have been the specific targets of torture.[10, 11]

Health assessments routinely conducted with refugee entrants to Victoria by the Victorian Foundation for Survivors of Torture (VFST) indicated that seven in 10 had experienced psychological or physical violence of some kind.[12]

The word 'torture' is usually associated with the detention and brutal abuse of the individual. However, torture is also a strategy used by oppressive regimes and groups to destroy communities. Many different methods have been used and they continue to be refined in a way which maximise the climate of terror.[13]

Some common forms of torture are:[14, 15]

- severe beatings
- falanga: prolonged and severe beating of the soles of the feet
- deprivation of sleep and sensory stimulation
- use of psychotropic drugs
- electric shock: electrodes are placed on the body's sensitive areas such as the tongue, gums, fingertips, genitals and nipples
- burning with cigarettes, hot irons, burning rubber, welding torches, corrosive liquids
- mutilation: extraction of hair or nails, cutting with knives, amputation of body parts, insertion of objects under nails
- suspension: hanging by arms or legs for extended periods of time
- isolation and solitary detention
- sexual violence and rape of women, men and children: includes molestation, stripping, touching, gang rape, rape by animals, insertion of objects into the vagina or rectum
- starvation and exposure to heat and cold
- sham executions

- water or submarine torture: the head of the victim is forced under water usually containing faeces or urine until near suffocation; a break is then allowed and the process repeated many times
- being forced to maintain abnormal body positions for long periods
- forcing victims to witness the torture of others, including loved ones.

As for other traumatic events, torture rarely occurs as a single event. It is also important to consider that the traumatic nature of a horrific event lies in its meaning for individuals, families and communities. Understanding the helplessness, isolation, humiliation and degradation caused by torture is as important as knowledge of techniques used to inflict torture.

What are the physical sequelae of trauma and torture?

The physical sequelae of torture are as varied as the methods of torture practised and are too numerous to document here. References in this guide provide more detailed information for health practitioners on physical sequelae and appropriate management. See Section 4 (p.79).

Some common sequelae may include:

- brain damage
- chronic pain and poor mobility (can be due to fibromyalgia syndrome)
- missing teeth
- impaired hearing (which may result from beating and electrical torture)
- difficulties in walking (can result from falanga)
- bronchitis (can result from submarine torture)
- mutilation of body parts
- scars and disfigurement
- sexual and gynaecological dysfunction – pain from the testis, anal itching, fissures, fistulas and haemorrhoids, damage to cervix and uterus and other internal injuries and sexually transmitted diseases.

Many survivors do not have enduring physical sequelae but the lack of visible signs should not be taken to mean that physical torture has not occurred. Some forms of torture leave few visible signs.[16]

The psychological sequelae

Most of Australia's refugees will not have experienced one single traumatic event, but rather have been exposed to a prolonged climate of political and civil repression, armed conflict, and dislocation. The loss of loved ones in violent circumstances, the prohibition of cultural practices, prolonged deprivation of human rights and dislocation from one's community are commonly present.

There is now a large body of evidence demonstrating that people who are exposed to horrific, life-threatening events may experience psychological symptoms long after the event has taken place.[17, 18, 19] One constellation of symptoms, described in the Diagnostic and Statistical Manual (DSM IV-TR) as post-traumatic stress disorder (PTSD),[20] is exhibited by survivors of trauma and torture.[21, 22] Depressive disorders and anxiety disorders are also common.[23, 24]

Studies of survivor populations using clinical research tools indicate prevalence rates for PTSD of between 32% and 100%.[25, 26, 27, 28] Rates of depression of between 47% and 72% have been found in refugee and political detainee populations.[29, 30] 32% of adult Sudanese refugees in a North Ugandan refugee camp had PTSD. 20% of children had chronic PTSD. Most common traumatic events were: 90% forced isolation from others, 91% forced separation from family members, 83% lack of food or water.[28]

It is not uncommon for survivors of trauma and torture to somatise their psychological stress, with patterns of somatisation varying between cultural groups.

Refugees also experience the psychological problems of any population. This needs to be considered in any assessment process.

KEY POINTS

Key symptomatic features of post-traumatic stress disorder

- The traumatic event is persistently re-experienced: recurrent and intrusive recollections of traumatic event, recurrent distressing dreams, acting or feeling as if the traumatic event is recurring, intense distress in response to reminders, physiological reactivity to cues reminiscent of event
- Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness: efforts to avoid reminders in thought or activities, marked diminished interest in significant activities, feelings of detachment from others, restricted range of affect, sense of foreshortened future
- Persistent symptoms of increased arousal: difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, exaggerated startle response.

Full list of diagnostic criteria can be found at mental-health-today.com/ptsd/dsm.htm

For more information about mental health effects see Department of Mental Health and Substance Dependence, World Health Organization (WHO) (2003) Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors, WHO, Geneva www.who.int/mental_health/media/en/640.pdf.

Psychological effects go beyond the symptomatic. The psychological effects of trauma and torture can be far more pervasive than those captured by diagnostic categories.[31, 32]

Grief is the normal response to loss and is not considered a mental health problem. Nevertheless, grief can affect everyday functioning to a debilitating extent and needs to be considered in assessment and treatment planning.

A consideration of the following highlights the far reaching effects of the response to trauma:

- Ability to carry out everyday tasks and attend to basic needs can be seriously impaired by feelings of powerlessness and lack of connection to others.
- Learning ability, which is crucial to adjustment in a new country, is seriously disrupted by poor concentration, memory impairment and sleep disturbance.
- Pain, whether caused by injuries or psychosomatic in nature, can be debilitating.
- Relationships are affected by distrust or loss of faith in people.
- Survivor guilt and guilt about choices that had to be made can prevent people from enjoying life, and they may expiate guilt through self-destructive behaviour.
- Anger and aggressive behaviour can result from low frustration tolerance as a result of stress and lack of sleep, as a protest against loss, as a response to injustices and as a reaction to shame and guilt.

The sensory nature of traumatic memory

"There were thirty soldiers with tommy-guns. Once I identified him they did not want me anymore, but I wanted to see what they were going to do to him. He asked me to go away because he might lose his courage and feel sad to know I was watching him. But I wanted to stay with him. He told them that he was not afraid of their bullets. It was terrible! Thirty of them! They all shot at once with their tommy-guns. I cried and covered my face like this and then fainted. For fifteen days I was without consciousness. I still remember the scene. It was like torture. I can still see how he fell with all those bullets."

— Refugee from Ogaden, Ethiopia

The key symptoms, signs and behavioural changes that may be exhibited by survivors of trauma and torture are outlined in Table 3.1 (p.52).

It is important to emphasise that there is a wide range of reactions to traumatic events. Whereas, for some, psychological sequelae can persist over a lifetime and be debilitating, for other people of refugee backgrounds, adverse effects may not impact on their daily functioning. Others may overcome such effects with family and community support, favourable social and economic circumstances, and through their personal resources.

TABLE 3.1 Trauma and torture: key psychological sequelae

KEY PSYCHOLOGICAL SEQUELAE OF TORTURE AND TRAUMA	MANIFESTATIONS Italicised symptoms and signs are included in diagnostic category post-traumatic stress disorder (PTSD, DSM IV)
Anxiety and helplessness	Physiological and somatic Panic attacks, pain, psychosomatic symptoms, startle reaction. Cognitive Poor concentration and memory, confusion, apprehension, hypervigilance, excessive worrying, anticipating the worst, intrusive memories of traumatic events, over-reaction/phobic perception of stimuli reminiscent of the traumatic events, flashbacks, nightmares, sleep disturbance, constricted receptivity to information, dissociation. Behavioural Avoidance and escape behaviour of potentially fear evoking situations, passivity, withdrawal, detachment from others. Impulsive behaviour, aggressive behaviour
Loss	Grief Numbness, denial. Pining, yearning, pre-occupation with loss. Anxiety, emptiness, apathy and despair, anger. Risk taking behaviour. Changes to relationships Dependency, overly self-sufficient. Guardedness, suspicion, withdrawal. Fear of renewed loss, fear of intimacy. Fear of contaminating others with death. Depression Pessimism, hopelessness. Loss of interest. Lack of energy. Sleep disturbance, appetite disturbance. Self degradation, self-blame. Suicidal thoughts and plans.
Shattered core assumptions	Loss of trust, sense of betrayal. Ready idealisation and devaluation of others. Loss of meaning and sense of future of human existence Sensitivity to injustice. Moral concepts affected. Loss of continuity of self, loss of identity.
Guilt and shame	Preoccupation with feelings of having failed to do something more to avert violence. Use of fantasy to repair damage done during traumatic events. Self-destructive behaviour. Avoidance of others or aggression due to shame. Experience of pleasure inhibited. Self-derogatory comments, overly deferential behaviour.

The settlement process and its psychosocial effects

As indicated in Section 1 (p.15), people from refugee backgrounds may be exposed to further negative influences on their psychological health in the process of settling in a new country and may have limited access to those resources known to protect and promote their health, such as social support, employment and income.

Serious threats can persist once people have arrived in Australia, particularly when family members remain exposed to danger in the country of origin or transit. Countries from which refugees come often continue to be war zones or areas of systematic persecution. Characteristically, other significant family members have been left behind. Anxiety about their welfare continues and can maintain a sense of helplessness and powerlessness. Other refugees from the same culture can provide support but they can also remind the person of earlier trauma as well as represent an ongoing threat if they are perceived as being linked to perpetrators. An unfamiliar environment and the disruptive effect of symptoms, where they occur, can create anxiety about ever gaining control.[33]

TABLE 3.2 Influences in the settlement environment that may exacerbate trauma

The settlement environment	Possible psychological sequelae
Concern about the safety of friends and relatives facing ongoing conflict and deprivation in countries of origin	• Guilt • Anxiety
Loss of, or separation from, family and friends	• Attachment and relationship difficulties • Grief • Depression
Difficulties in accomplishing the tasks of settlement (e.g. learning a new language)	• Perceived loss of control • Anxiety • Loss of a sense of purpose, hope and an altered view of the future • Inability to concentrate
Lack of understanding, discrimination and hostility in the community	• Guilt, shame, isolation • Loss of trust
Minority status in the dominant Australian culture	• Loss of meaning, identity, status and a diminished sense of belonging

Separation from family members, dislocation from culture and tradition contribute to a sense of ongoing loss. Exposure to encounters with people who have little or no understanding of their backgrounds maintains distrust and isolation. On the other hand, the possibility of a new life restores a sense of purpose and meaning and can mitigate loss.

Guilt and shame can persist if new humiliations from racial prejudice occur. It is particularly important to consider the impact of guilt which results from having left relatives behind in precarious circumstances. Such guilt commonly manifests as difficulty eating and serious concerns for being able to save enough money to send to relatives and loved ones.[34]

For individuals granted the 866 visa (i.e. those who sought asylum via onshore processing), the effects of long-term detention have a bearing on settlement stress and outcomes.[35, 36]

The psychological implications of uncertain migration status

Asylum seekers face particular stresses owing to their uncertain migration status, limitations on their access to benefits and, in some cases, owing to experiences in detention centres. Recent studies indicate that this group is vulnerable to being retraumatised and have particularly poor physical and mental health.[37]

Typical stresses faced by asylum seekers include:

- a limited capacity to plan for their future, develop social connections and a sense of belonging in Australia
- detention centre experiences may compound a sense of injustice and loss of control and serve as painful reminders of persecutory practices in countries of origin
- perceptions that they are not being believed by the Australian government or that, compared with those groups granted permanent visas, they are being treated in a discriminatory fashion
- feelings of powerlessness resulting from the limited control over their lives
- exposure to unsympathetic or hostile attitudes in the media and the wider community (a particular concern for boat arrivals and those from Muslim backgrounds)

- no or uncertain access to Family Reunion provisions (see Section 9) resulting in limited access to the protective effects of family relationships and support and unresolved anxiety about the safety of loved ones still in dangerous circumstances overseas
- limitations on their access to the resources required for positive mental health (e.g. English language tuition, secure housing)
- in the case of asylum seekers, the stress associated with the refugee determination process during which they may be required to recount painful past experiences and be questioned about the accuracy of their story. This may leave people with a sense of shame and of not feeling believed. Many survivors feel that they relive their experiences every time they retell them.

The impact of detention on concentration and memory

An Australian study on the long-term mental health problems faced by refugees formerly detained in Australian detention centres demonstrates that prolonged detention has long-term deleterious effects on both concentration and memory.[35] It is important that clients are assisted to understand that, as with physical fitness, their mental fitness can be restored over time, given appropriate stimulation, time and opportunities for autonomous decision-making and problem-solving. Ensuring accessible pathways to service provision and supportive communities will optimise the potential for recovery. For more information see Section 8 > Strategies for supporting new arrivals to access health services (p.281).

> “Nothing stays in my memory. Nothing. I must try ten times, twenty times, and in the end, I forget it all again.”
>
> – Tertiary-qualified person of refugee background, on long-term impact of detention on memory and concentration.[35]

Approaches to assessment of trauma

Should I ask if the person is a survivor of trauma and torture?

In practice, clients infrequently disclose traumatic experiences. However, an understanding of the extent to which the person has experienced violence, torture and witnessed horrific events is relevant to diagnosis, management, treatment and making referrals.

The extent to which you actively enquire about this information will depend on your professional role with the client and whether you have established rapport with the client.

Awareness that the person has come from a 'refugee-like' situation will often be sufficient to orient care to their needs, and specific details will not be required. Knowing the country of origin and country or countries of transit will give you considerable information about the experiences clients from particular regions are likely to have endured. See Section 10 (p.309).

The more information you have about a country and its political, economic and social conditions, the easier it is to 'read between the lines' and ask appropriate questions. Links to country information sites are found in Section 10 (p.309).

Some clients will disclose readily, especially if they sense that the health professional is knowledgeable about their previous and current circumstances. Providing the opportunity for a client to discuss traumatic experiences in a sensitive and supportive environment can have a powerful therapeutic effect. For some people it may be the first time someone has shown an interest in the experiences they have endured, and may bring a sense of great relief. Many survivors have been told by their torturers that no-one will ever believe them. Listening and responding sensitively to their experiences can help to reduce feelings of isolation and counter the destructive messages of the torturer.

The questions on the next page are not intrusive and allow the client to elaborate if they should wish. They can assist in establishing a history of traumatic events, displacement and significant losses. The questions can be used in addition to those which appear in the health assessment. See Section 6 (p.227).

Questions to establish a history of trauma and displacement

- When did you leave your country?
- Were you forced to leave? What were the circumstances which led you to leave?
- Which countries have you lived in before coming to Australia? How were conditions in those countries? Have you spent time in a refugee camp? How were conditions in those countries?
- Terrible things have often happened to people who have been forced to leave their countries. I do not need to know the details about what you have been through, but have you had any terrible experiences that might be affecting you now?

A comprehensive psychosocial assessment

A comprehensive psychosocial assessment consists of several parts and includes the trauma history:

- Client information: country of origin, countries of transit, date and means of arrival and preferred language
- Family composition, genealogy, whereabouts of close family members and quality of family functioning
- Extent of pre-arrival exposure to extreme circumstances, human rights violations and violence (trauma history)
- Current stresses associated with settlement
- Social resources and support
- Psychological health.

All of these areas are included in Section 6 (p.227). Table 3.3 (p.58) summarises the reasons for eliciting information about these key areas.

TABLE 3.3 Comprehensive psychosocial assessment: key areas and their rationale

Consider	Will indicate	
Country of origin	• Nature and likely duration of exposure to hardship, privations, violence, conflict	• Services access and familiarity
Country (countries) of transit	• As above	
Date of arrival	• Settlement stresses can be anticipated • Need for orientation	• Need for refugee health assessment
Means of arrival	• Traumatic journey to Australia	• Asylum seeker and detention history
Migration status	• Benefits and entitlements available • Relevant services	• Asylum seeker and detention history • Cultural background
Preferred language	• Interpreter requirements	
Religion (preface with explanation for enquiry)	• Beliefs and practices that need to be accommodated in care	
Family composition and family functioning	• Family links • Missing family members • Stresses and psychological reactions can be anticipated regarding separation, death, concern for family members left behind	• Emotional and practical support available • Need for referral for migration assistance, tracing services • Indicators to promote assessment of other family members
Trauma History	• Extent of exposure to traumatic experiences and likelihood of psychological (and physical) sequelae • Importance of consideration of gender	• Implications for family functioning and health of other family members • Need for referral(s) • Anxieties that may manifest in medical setting
Current stresses	• Need for settlement support and material needs – housing, economic concerns	• Need for psychological support • Relevant referrals
Social resources and support	• Need for links to community/services	• Need for one to one professional relationship
Psychological health (including client's interest in sharing psychological concerns)	• Screening (see overleaf) will indicate areas to follow up	• Referrals for specialised assistance • Options for most appropriate response

Mental health/psychological screening

In the experience of torture and trauma services, the following areas to enquire about are very acceptable to clients, are not overly intrusive and easily lead to further questions that can establish a diagnostic picture. See also Section 6.

- Appetite
- Energy levels
- Daily activities
- Memory
- Concentration
- Sleep
- Mood/affect
- Worries/plans for future.

RESOURCES

There are a number of screening tools available that have been designed for use in the primary healthcare setting. One tool, validated in cross-cultural settings, is the PRIME-MD, a tool for identifying mental disorders in primary care practice and research. PRIME-MD and other instruments, which can be used in the assessment of depression, anxiety, post-traumatic stress disorder and psychoses can be found at: The Victorian Transcultural Psychiatry Unit (VTPU) Mental Health Instruments in Non-English Languages page www.vtpu.org.au/resources/translated_instruments.

These tools can be used in a refugee population with due regard for cross-cultural validity. In general, the tools are best used as a guide to questions that can be asked. Their suitability as self-report instruments is still not established.

The impact of torture and trauma experiences on the consultation

Torture and trauma experiences may impact on the consultation in the following ways:

- anxiety, distress as the result of intrusive memories (sometimes triggered in the course of consultation), memory loss, confusion and inability to concentrate, may interfere with the client's ability to 'hear' and understand questions and instructions
- some survivors may have incurred brain damage in the course of torture, and this may interfere with memory and concentration
- the doctor's surgery and instruments used in the conduct of procedures may remind a survivor of their torture experience and reinforce a sense of helplessness and powerlessness, or induce anxiety, panic or avoidance of further consultations
- doctors and other health professionals may unwittingly invoke fear, as health professionals have been actively involved in perpetrating torture in some persecutory regimes[38]
- confusion and memory loss may result in inconsistencies in information provided by the client
- survivors may be particularly sensitive to unfamiliar situations and may exhibit signs of hypervigilance and startle reactions
- feelings of shame may make being physically approached and touched a disturbing experience. This may be particularly the case for survivors of rape and other forms of sexual torture
- anger, hostility and mistrust, particularly of authority figures, are not uncommon responses, and may interfere with obtaining information required for diagnosis and treatment.

Approaches to conducting a consultation with a client experiencing a trauma reaction are outlined in Section 6 (p.227).

The role of health professionals in providing psychological support to survivors

Some survivors will require counselling and psychotherapy, which should be provided by a professional with appropriate qualifications. Nevertheless, there is the potential to provide psychological support in the context of the assessment or diagnostic interview conducted by many health professionals (e.g. doctors, refugee health nurses, maternal and child health nurses).

Therapeutic ingredients of an interview include:

- establishing rapport and outlining the purpose of the contact
- gathering information, including assessment, problem definition and needs identification
- determining outcomes and ascertaining how the client wishes to proceed
- exploring alternatives and personal dynamics
- transferring learning to everyday life.

When well conducted, an interview can provide significant psychological benefits.

- Demonstrating understanding and a genuine caring approach can help to reduce the client's sense of isolation.
- Providing the opportunity to share unbearable knowledge can provide relief to the client, as the health practitioner provides a witness to the client's experiences; experiences they sometimes cannot believe themselves.
- Listening to the client's feelings and relating them to past and current stressors can enhance the client's capacity to problem-solve and take control themselves.
- Looking for, and identifying, strengths raises self-esteem.
- Seeds can be planted about what is needed for recovery.
- The worker can begin to influence and challenge central beliefs which maintain the reaction to trauma (e.g. self-perceptions of external isolation, weakness, low self-value, culpability and failure or perceptions of oneself as permanently damaged).
- Clarity about the worker's availability and the length of the consultation will improve control and predictability.

Ambivalence about disclosing torture is normal, and reflects the client's struggle to remember or forget the past. Sometimes an especially good interview that has included disclosure will be followed by a cancellation.

How should I respond to a disclosure?

- Acknowledge the person's experience and its associated pain (e.g. 'That's a terrible thing you have been through.'). This will help to validate the person's reaction.
- Remind the person that their reaction is a characteristic response to their circumstances. For example, it is common for survivors to blame themselves – seeing their reactions as a sign that they are abnormal or weak.
- Avoid false reassurance, but instilling hope is important. Indicate that, with time and appropriate support, improvement can be achieved.
- Expect that the person who has disclosed a painful event one day may be unwilling to talk about it in subsequent consultations. Rather than pushing them to do so, talk about other things that may be troubling them in the 'here and now'.
- Expect inconsistencies in the person's retelling of their trauma history.
- In completing the interview, explain to the person how you are able to assist them.

> "... there is an opportunity to build dignity with every human encounter. Given that it is the human hand that has perpetrated violations it is the human hand that has the power to heal wounds."
>
> — Ida Kaplan and Kim Webster[39]

Management of psychological sequelae

Approaches to the management of symptoms in people of refugee background are similar to the management of these conditions in the general client population. There are several types of interventions with evidence for their efficacy. These are described in the following sections. In general, a combination of approaches, which includes the biological, psychological and psychosocial, is recommended as most effective.[40]

Cross-cultural responsiveness is integral to effective management.

It is important to:

- provide feedback to the client on your diagnosis or opinion of their condition
- explain what you understand to be the likely causes of the condition (psychological, social and physiological)
- outline treatment options so that the client is able to make a choice.

If the client presents with symptoms and behaviours such as suicidality or other high-risk behaviours, psychiatric management should be arranged in the usual way.

The Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder have been prepared by the Australian Centre for Posttraumatic Mental Health (ACPMH). The guidelines have been endorsed by the NHMRC. They include a section on refugees and asylum seekers. The guidelines are available at www.acpmh.unimelb.edu.au/resources/resource-asdptsd_guidelines.html.

Pharmacological treatment

Medication may be required to manage symptoms severe enough to interfere with the client's functioning. However, health professionals working extensively with torture and trauma survivors are of the view that optimum treatment involves non-pharmacological approaches either in addition to medication or as the primary treatment modality.[41]

Accordingly, where a client presents with persistent symptoms believed to be related to trauma, consideration should be given to referring to a psychiatrist, psychologist or a counselling agency, such as the specialist service for survivors of trauma and torture in your state or territory. See Section 11 (p.323).

There are several reviews of literature on the efficacy of drugs in trauma-related conditions for the general population.[42] The degree of improvement for different symptom groups varies across studies, as do reported side effects.

In the Cochrane Review of PTSD pharmacotherapy, a number of recommendations were made that apply to the general population.[43] The applicability of these recommendations to the refugee population is not reported.

An extensive review of pharmacotherapy, conducted by the American Psychiatric Association included cross-cultural practice guidelines:

- Cultural values may affect the decision to take medication.
- Cultural values may affect adherence to medication regimes.
- There are differences in metabolism among ethnic groups affecting therapeutic benefits and adverse effects of medication.

There are a number of studies that specifically examine the efficacy of SSRIs, antidepressants and other psychotropic drugs in people of refugee backgrounds.[44]

Complementary therapies

Referral to a complementary therapist (e.g. masseur, naturopath) may also be useful although the cost of these services needs to be considered. In some states FASSTT service providers offer free services to people of refugee background. Complementary approaches are acceptable to many refugee clients, and can contribute to the management of many of the physical and psychological sequelae of trauma and torture. For further information see Section 7 > Complementary therapies (p.276).

Psychological interventions

Counselling and therapeutic methods that have been found to be effective in reducing symptoms in the refugee population are cognitive behaviour therapy,[45] exposure therapy, and the testimony method.[46]

Extensive reviews of the efficacy of psychological approaches to trauma-related conditions in the general population are available. As for pharmacotherapy, the degree of improvement varies, and some approaches, although found to be beneficial overall, can lead to a worsening of symptoms in some clients. In general, benefits have been shown for behaviour therapy and cognitive therapy. The number of studies conducted for other approaches is more limited but benefits have also been shown for psychodynamic psychotherapy and group therapy.

Many strategies that promote recovery from torture and trauma-related problems are common to both counselling and other supportive approaches. They include:

- information provision and giving explanations for what you are doing
- setting realistic goals that enhance control and a sense of achievement
- gradual exposure to feared situations
- addressing settlement problems
- providing a predictable and safe environment
- linking with supportive groups and agencies
- strengthening personal resources
- a respectful and accepting attitude
- facilitating coping and problem-solving skills
- encouraging opportunities for sharing and the experience of pleasure.

What is distinctive about counselling is that the counsellor has the expertise to assess the specific causal determinants, both current and historical, of psychological problems in order to implement specific strategies to overcome maladaptive behaviour patterns, reduce symptoms and emotional distress, and build coping skills.

The quality of the relationship in counselling is critical to recovery.[47] The advantage of a longer-term professional relationship is that fears concerning close relationships, dependency and isolation, which are sequelae of torture and trauma can be dealt with. Lack of trust, anger and disappointment emerge in the relationship and can be talked about.

Counselling often has to be integrated with advocacy and referral to other agencies because of multiple presenting needs.

Group counselling can be a very helpful approach for addressing problems of social isolation, grief, and symptoms of anxiety, depression and PTSD.[48]

Discussing counselling with your client

Counselling requires a significant level of engagement and investment by the client themselves. Some clients may not want a counselling referral, fearing that talking about past experiences may make them worse. Further, those who have only recently arrived in Australia may be preoccupied with the immediate challenges of resettlement. Depending upon their country of origin, clients may be unfamiliar with counselling, and its purposes may need to be explained to them. Survivors seldom understand that their behavioural responses are the consequence of their traumatic experiences. Accordingly, they may interpret them as signs of weakness. This may exacerbate their feelings of helplessness and anxiety.

Counselling, which focusses on the individual, may be unacceptable in some cultures where greater emphasis is placed on whole families or communities working through a problem together.[49] Some clients may be wary about a referral, seeing the need for psychological help as the preserve of those with an identifiable mental illness.

Clients from countries where there has been medical involvement in torture, or from small refugee communities, may fear that their confidentiality may be breached in the process of seeking psychological support.

Health professionals can play an important role in preparing a client for counselling by explaining its purposes in simple terms and in ways that normalise and de-stigmatise seeking help for psychological issues. It is also important to address the client's fears that talking about their past experiences will make them worse. Consider the following approach:

'Many people who have experienced terrible things have worries, fears and experiences such as nightmares which do not go away by themselves. Counsellors can help with such experiences so that they do not interfere with daily life so much. Many people feel better when they discuss their worries and how to deal with them, although at first it seems that it will make things worse.'

Reassure the client that strict confidentiality is observed by counselling agencies.

If a person indicates that they are not interested in pursuing help, offer them information for self-referral at a later date. Show acceptance of their decision and indicate your willingness to discuss the matter further. Be aware that it may take some time and a great deal of encouragement for a person to accept a referral for psychological assistance.

KEY POINTS

Discussing counselling with your client

If a client presenting with persistent symptoms has not disclosed a trauma history to you, try the following approach:

- Begin with saying what you have noticed by way of a problem. For example, 'You have mentioned that you have been crying a lot.'
- Ask the person if there is anything you can do to make things easier.
- Using some of the questions outlined in this guide, explore the possibility that the client's symptoms are related to past trauma.
- Affirm that it is not unusual for people to feel the way they do, particularly if they have experienced hardships and violence before coming to Australia.
- Tell them that there are services that deal with problems that have resulted from trauma due to war, civil violence and political oppression. This will enable you to ascertain their interest in a referral.

KEY POINTS

- Making a referral for counselling.
- Before offering a referral, make sure that you have time to undertake the necessary follow-up (e.g. phone calls, follow-up consultation). It is important only to offer what you are able to deliver.
- Agree to inform the client of the outcome of the referral (e.g. whether they have been placed on a waiting list, how and when they will be contacted).
- If a person indicates they do want a referral, explain that you could refer them, if they agree, or explain how they can refer themselves.
- If referring to a counselling agency, explain that there may be a waiting time.

Making a referral to a service for survivors of trauma and torture

Specialist services for survivors of trauma and torture have been established in each Australian state and territory. These services provide a range of counselling and advocacy services, including family case work and natural therapies. Services are non-denominational, politically neutral and non-aligned, and are free and confidential. A waiting period may apply.

Your client may benefit from a referral to the service in your state or territory service if they:

- are believed to have a history of trauma and torture prior to arrival in Australia
- are experiencing psychological and emotional distress believed to be related to trauma and torture
- wish to seek assistance from a torture and trauma service and consent to a referral being arranged.

For referral to a torture and trauma service in your state visit the Forum of Australian Services for Survivors of Torture and Trauma website fasstt.org.au.

A consultation service to other health and settlement providers working with survivors may also be available.

Which service should I refer to?

This will depend on:

- the client's choice of treatment modality
- the client's understanding of and motivation to engage in counselling
- your assessment of the extent to which settlement issues feature in the client's psychological state. Specialist torture and trauma agencies generally adopt an approach that combines counselling with assistance in addressing practical issues such as accessing housing, employment and education
- whether the client requires urgent attention
- your assessment of the extent to which the client's symptoms require specialist pharmacological management. For some clients referral to both a psychiatrist and a counselling and support agency may be indicated.

If you are unsure about the most appropriate referral for your client, consider consulting a counsellor at the service for survivors of torture and trauma in your state or territory. See Section 11 (p.323).

KEY POINTS

Assisting a client who appears to have somatised their psychological distress

Consider the following approaches:

- Take complaints seriously and conduct appropriate investigations. Often refugee clients fear that their experiences have caused irreparable harm. Thorough investigation can often serve as reassurance when nothing is physically wrong.
- Help the client to make connections between body and mind. The example of the body's physiological response to extreme danger can be useful to explain this.
- Avoid dismissing somatic complaints or giving reassurances that they will 'go away with time'. The client may interpret this as trivialising their concerns.
- If somatic symptoms persist, consider a referral for counselling and support. This may involve establishing the client's trauma and torture history if they have not already disclosed this to you.

The impact of the refugee experience on families

Previous exposure to traumatic experiences, accompanied by the stresses associated with resettlement, can contribute to high levels of family tension and breakdown.

Characteristics of the impact on families

The refugee experience can impact on families in the following ways:

- roles within the family are often dramatically altered
- traumatised parents can have their capacity for emotionally supporting and protecting their children reduced
- parents fear 'losing' their children to the new culture
- extreme disturbances in parents become new trauma for family members
- financial difficulties and generational conflict produce extra burdens on family members
- guilt associated with leaving family behind can disrupt emotional recovery for all family members
- considerable pressure can fall on children to be successful with little accommodation of their settlement stresses.

The impact of trauma on children and young people

Refugee children and young people will have experienced a wide range of stressors and traumatic events prior to their arrival in Australia. They include:

- coming under combat fire and bombing
- destruction of homes and schools
- perilous journeys
- separation from care givers
- sudden disappearances of family members or friends
- loss of family members in violent circumstances
- threat of harm to family members and friends
- refugee camps
- witnessing violence and death
- forced conscription
- physical injury
- arrest, detention or torture
- sexual assault.

Stressors can continue once children and young people arrive in Australia. As well as changes in their families and family relationships, on arrival in a new country they are required to learn a new language, adapt to a new set of cultural norms, and orient themselves to a new and unfamiliar school system.

Unaccompanied young people face additional stresses, and can be at risk of destitution if unsupported in Australia.

There is a considerable body of evidence to show that children often experience a psychological reaction to trauma not dissimilar to that found in adults.[50, 51, 52]

There may also be important and far reaching impacts on social, cognitive and neurological development, for instance, affecting the early formation of the capacity for attachment, sense of self, affect modulation, learning capacities and development of the child's social framework.

This may manifest itself in children in a number of ways, including:[53]

- withdrawal, lack of interest and lethargy
- aggression, anger and poor temper control
- tension and irritability
- poor concentration
- repetitive thoughts about traumatic events

- poor appetite, overeating, breathing difficulties, pains and dizziness
- regressions (e.g. return to bedwetting)
- nightmares and disturbed sleep
- crying
- nervousness, fearfulness and proneness to startle
- poor relationships with other children and adults
- lack of trust in adults
- clinging, school refusal
- hyperactivity and hyper-alertness.

As with adults, some children and young people will experience few or no adverse effects in response to stressors and traumatic events. Some of the factors that have been found to be protective in minimising psychological distress are social support, peer support and parental wellbeing.[54, 55]

Families play an important role in helping their children meet the developmental tasks of childhood and adolescence and in protecting them from the effects of adverse life events. However, the refugee experience can affect the capacity of families to carry out this role, particularly when parents or care givers experience mental health difficulties as a result of their torture and trauma experiences. The feeling of guilt associated with being unable to protect children may serve as a barrier to acknowledging adverse effects.

KEY POINTS

Assisting a parent whose child is experiencing a trauma reaction

Healthcare providers working with child survivors of trauma advise parents to:

- support their primary attachments with significant people
- encourage children to express their emotions
- offer children support while they are upset
- ask children questions to find out what they are thinking and imagining
- reassure children about the future, especially the small details of their lives which are such an important part of their world
- encourage children to be children, to play, explore and laugh and to do usual things for their age
- maintain routine and predictability as this helps children to believe that life is secure and predictable
- minimise change and, when it is necessary, to take time to prepare children for it
- give children feedback about how they are going
- avoid making this the time to correct any bad habits
- avoid over-reacting to difficult behaviour, as this may be children's way of letting their tension out
- give the child time to adjust to a new situation
- make time for just being together.

Interventions for refugee children and young people

Interventions can occur in a range of settings. The medical setting can be advantageous because it is less associated with the stigma of acknowledging emotional difficulties than a specialist mental health service. Schools can be an optimal setting because stigma is reduced, involvement of parents can be facilitated and the school itself provides a range of opportunities for intervention.

Reviews on the effectiveness of interventions for refugee children and young people highlight the importance of employing a diversity of modalities: individual, family and group therapy, preventive interventions and school-based interventions.

KEY POINTS

Recognising PTSD in children

In the primary care setting, in recognising children who may have post-traumatic stress disorder:[56]

- Consideration should be given to asking the child and/or parents about sleep disturbance or significant changes in sleeping patterns.
- Questioning the children as well as parents or guardians will improve the recognition of PTSD.

A comprehensive set of recommendations for clinicians working with young refugee populations, put forward by the Refugee Trauma Task Force of The National Child Traumatic Stress Network (NCTSN) www.NCTSNet.org.au (2005) Mental Health Interventions for Refugee Children in Resettlement : White Paper II can be found at: www.nctsnet.org/nctsn_assets/pdfs/promising_practices/MH_Interventions_for_Refugee_Children.pdf

Family violence and women

Immigrant women subject to family violence are a vulnerable group. This is particularly the case for women from a refugee background as:

- they may lack family and community support
- if they are experiencing a trauma reaction they may fear being alone – for some, an unsatisfactory union may be better than having no adult relationship
- their tolerance of their partner's violent behaviour may be heightened by the knowledge of the trauma to which he has been subject
- they may be unaware of Australian laws prohibiting family violence

- inability to speak English and a lack of knowledge of alternative housing, income and support services make it difficult for a refugee woman to leave a violent relationship
- they may encounter difficulties in accessing legal and support services owing to language and cultural differences
- they may have fears that their confidentiality may be breached by support services
- many refugee women come from traditional societies in which there are strong cultural prohibitions against separation and divorce, the pressure on women to 'keep the family together' may also be particularly strong given the degree of trauma and dislocation to which refugee families have been subject
- women in refugee families may be wary about involving the police and legal personnel in family matters given their experiences of legal and law enforcement systems in their countries of origin.[57]

Working with refugee families in which domestic violence is occurring may be challenging, particularly if the perpetrator has himself been subject to trauma and torture.

KEY POINTS

Refugee families and family violence

If there are signs that violence is occurring, ask the woman if this is the case (when her husband or partner is not present). Use a professional interpreter if possible.

Provide information on support options and legal rights, including the fact that violence between intimates is illegal.

Take steps to ensure the woman's safety. If she wishes to leave, support her and give her the telephone numbers of services able to assist her to do so. See Section 11 (p.323).

If she chooses to remain in the home, respect her decision. Support her by giving her telephone numbers she can contact in the event of a crisis. See Section 11 (p.323).

The temptation may be to rationalise the perpetrator's behaviour in light of his own experience of torture. However, this does not justify his behaviour nor minimise the danger to his partner and children.

Consider consulting with a family violence outreach worker on how you might best assist your client.

Consider consultation with local family support services.

For information on services for women affected by family violence see Section 11 (p.323) or contact your state or territory department of health or community services.

RESOURCES

There are several family violence guidelines available from:

- NSW www.whfs.org.au/informationLibrary.
- DVIRC www.dvirc.org.au/TrainingHub/GPsKit.htm.
- DVRCV www.dvrcv.org.au/publications/books-and-reports/guide-for-general-practitioners.
- RACGP www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/Familywomenviolence/Intimatepartnerabuse/20060507intimatepartnerviolence.pdf.
- Victoria www.dhs.vic.gov.au/__data/assets/pdf_file/0009/581256/practice-guidelines-women-and-children-fv-counsell-support.pdf.

Sexual assault

Rape and other forms of sexual torture are commonly perpetrated by persecutory regimes against women and men. Women who have been subject to rape face particular concerns since they often suffer rejection by partners, other family members and even their communities. The same guidelines apply in dealing with a disclosure of rape as those described for other forms of torture. Also consider consultation with, or referral to, a Centre Against Sexual Assault (see Section 11 (p.323)) or contact your state or territory health authority for details. A counsellor/advocate can be reached at these centres usually on a 24-hour basis.

Where sexual assault is a concern, male general practitioners (GPs) should ask the client if she or he would prefer a referral to a female doctor.

The availability of testing for sexually transmitted infections (STIs) may be raised with the client when and if appropriate. When deciding whether to encourage refugee women to undertake STI screening, take into account the invasive nature of some of these tests and the anxiety that may be associated with them. Also be aware that tests for some STIs may have been undertaken as part of pre-arrival screening for some applicants. See Section 6 (p.227).

Whatever your management plan, it is important to be watchful for clinical symptoms and signs. Chlamydia, often asymptomatic, can be detected by urine test, which has the advantage of being non-invasive.

Sensitivity is similarly required in offering Pap tests and other gynaecological procedures to refugee women.

RESOURCES

Further resources and information are available at:

- Victorian Foundation for Survivors of Torture (VFST) (2005) Sexual Violence and Refugee Women from West and Central Africa www.foundationhouse.org.au/LiteratureRetrieve.aspx?ID=25047.
- The Jean Hailes Foundation for Women's Health, Health for Women: www.healthforwomen.org.au/health-issues/85-violence-against-women-in-australia.
- Royal Australian College of General Practitioners (RACGP) Sexual Health: www.racgp.org.au/afp/200906.
- Royal Women's Hospital, Women's Health Matters: www.thewomens.org.au/WomensHealthMatters#WHM_FactSheets.

Staying effective

Providing care to a highly traumatised client can evoke emotional feelings in the health practitioner, which may influence the provision of appropriate care as well as lead to personal stress.

Health practitioners and others working with refugee clients have found that they are better able to deal with this stress if they have the opportunity to talk about their work with others.

Ways of achieving this include:

- accessing formal professional debriefing, contact details can be obtained through your professional association or union or, in the case of general practitioners (GPs), the local Division of General Practice
- arranging formal times for case discussion or review
- arranging regular meetings with colleagues whose client profile is similar to your own
- developing a reciprocal arrangement with a colleague whereby you are available to each other for case discussion or 'debriefing' when required
- undertaking further training in refugee health and wellbeing.

PRACTICE TIP

Professional development and capacity building

Given the changing nature of Australia's humanitarian response and emerging research in this area, regular skill development is recommended for health professionals who work with survivors of torture and trauma.

Information regarding professional development in your state or territory is available from your state or territory torture and trauma service. For contact information visit:

The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) www.fasstt.org.au.

References

1. Victorian Foundation for Survivors of Torture Inc. (VFST) (1998). Rebuilding Shattered Lives. Parkville: VFST.
2. United Nations Children's Fund (UNICEF) (2005). The Impact of Conflict on Women and Girls in West and Central Africa and the UNICEF Response. Retrieved from < www.unicef.org/emerg/files/Impact_conflict_women.pdf >
3. Perea, P. (2007) 'Physical methods of torture and their sequelae: A Sri Lankan perspective'. Journal of Forensic and Legal Medicine, 14, 146-150.
4. International Rehabilitation Council for Torture Victims (2011, June). Up to 30% of Refugees are Torture Victims, Highlights the IRCT on World Refugee Day. Retrieved from < www.irct.org/Default.aspx?ID=3843&PID=13717&M=NewsV2&Action=1&NewsId=3221 >
5. Moussa, H. (1993). Storm and Sanctuary: The Journey of Ethiopian and Eritrean Women Refugees. Canada: Artemis Enterprises.
6. Musse, F. (1994). 'Women victims of violence: Rape in Kenya's refugee camps'. RPN, 16 (March), 17-20.
7. Wilkes, S. (1993). 'Don't let the sun go down'. Refugees, (December).
8. Karen Women's Organisation (KWO) (2007). State of Terror: The Ongoing Rape, Murder, Torture and Forced Labour Suffered by Women Living Under the Military Regimes in Karen State. Mae Sot: SRDC.
9. Shan Human Rights Foundation (SHRF) & Shan Women's Action Network (SWAN) (2002). License to Rape: The Burmese Military Regime's Use of Sexual Violence in the Ongoing War in Shan State. Chiang Mai: SHRF and SWAN.
10. Green, C. (2007). 'Politically-motivated torture and child survivors'. Pediatric Nursing, 33(3), 267-271.
11. UNICEF (2006). The State of the World's Children 2006: Excluded and Invisible. Retrieved from < www.unicef.org/sowc06/pdfs/sowc06_fullreport.pdf >.
12. VFST (2010). Annual Report 2009-2010. Melbourne: VFST

13. International Rehabilitation Council for Torture Victims (IRCT) (2011). 2011 Global Report on the UN International Day in Support of Victims of Torture. Copenhagen: IRCT
14. UNICEF (2008). The State of the World's Children 2008: Child Survival. Retrieved from < www.unicef.org/sowc08/docs/sowc08.pdf >.
15. UNICEF (2011). The State of the World's Children 2011: Adolescents. Retrieved from < http://www.unicef.org/sowc2011/index.php >.
16. Medical Faculties of the Universities of Copenhagen, Odense and Aarhus & the Danish National Board of Health (1990). 'Medical aspects of torture'. Danish Medical Bulletin, 37(1), 1-88.
17. Herman, J. (1992). Trauma and Recovery: From Domestic Abuse to Political Terror (pp.1-4). Great Britain: Pandora.
18. Creamer, M. (1996). 'The prevention of post traumatic stress'. In P. Cotton & M. Jackson (Eds). Early Intervention and Prevention in Mental Health, 229-246.
19. Kuch, K., & Cox, B. J. (1992). 'Symptoms of PTSD in 124 survivors of the Holocaust'. American Journal of Psychiatry, 149, 337-340.
20. American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders (4th edn). Washington, DC.
21. Garcia-Peltoniemi, R.E. (1990). Clinical Manifestations of Psychopathology. In J. Westermeyer, C.L. Williams, & A.N. Nguyen (Eds) Mental Health Services for Refugees Mental Health Program. US Department of Health and Human Services, 49-50.
22. Somnier, F., Vesti, P., Kastrup, M., & Genefke, I.K. (1992). Psychosocial Consequences of Torture: Current Knowledge and Evidence. In M. Basoglu (Ed.) Torture and its Consequences: Current Treatment Approaches. Glasgow: Cambridge University Press.
23. Allden, K., Poole, C., Chantanvich, S., Ohmar, K., Aung, N.N., & Mollica, R.F. (1996). 'Burmese political dissidents in Thailand: Trauma and survival among young adults in exile'. American Journal of Public Health, 86(11), 1561-1569.
24. Mollica, R.F., Wyshak, G., & Lavelle, J. (1987). 'The psychosocial impact of war trauma and torture on Southeast Asian refugees'. American Journal of Psychiatry, 144(12), 1567-1572.
25. Kinzie. J.D., Fredrickson, M.D., Ben, R., Fleck, J., & Karis, W. (1984). 'Post traumatic stress disorder among survivors of Cambodian concentration camps'. American Journal of Psychiatry, 141, 644-650.
26. Carlson, E.B., & Rosser-Hogan, R. (1991). 'Trauma experiences, posttraumatic stress, dissociation and depression in Cambodian refugees'. American Journal of Psychiatry, 1148(11), 1548-1551.
27. Fox, S., & Tang, S. (2000). 'The Sierra Leonean refugee experience: Traumatic events and psychiatric sequelae'. Journal of Nervous and Mental Disease, 188(8), 490-495.
28. Peltzer, K. (1999). 'Trauma and mental health problems of Sudanese refugees in Uganda'. Central African Journal of Medicine, 45(5), 110-4.
29. Simpson, M.A. (1993). Traumatic Stress and the Bruising of the Soul. In J.P. Wilson, & B. Raphael (Eds) International Handbook of Traumatic Stress Syndromes (pp.667-684). New York: Plenum Press.
30. Mollica, R. F., Wyshak, G., & Lavelle, J. (1987). 'The psychological impact of war trauma and torture on South Asian refugees'. American Journal of Psychiatry 144. 1567-1572.
31. McIvor, J.R. & Turner, S.W. (1995). 'Assessment and treatment approaches for survivors of torture'. British Journal of Psychiatry, 166, 105-711.
32. Parker, M. (1996). 'The mental health of war damage populations'. IDS Bulletin, 27(3), 77-85.
33. Lindencrona, F., Ekblad, S., & Hauff, E. (2008). 'Mental health of recently settled refugees from the Middle East in Sweden: The impact of pre-resettlement trauma, resettlement stress and capacity to handle stress'. Social Psychiatry and Psychiatric Epidemiology, 43(2), 121-131.
34. Nickerson, A., Bryant, R.A., Steel, Z., Silove, D., & Brooks, R. (2010). 'The impact of fear for family on mental health of the resettled Iraqi Community'. Journal of Psychiatric Research, 44(4), 229-235.
35. Coffey, G.J., Kaplan, I., Sampson, R.C., & Tucci, M.M. (2010). 'The meaning and mental health consequences of long-term immigration detention for people seeking asylum'. Social Science & Medicine, 70, 2070-2079.

36. VFST (2011). The Victorian Foundation for Survivors of Torture Annual Report 2010-2011. Melbourne: VFST.
37. Silove, D., Steel, Z., & Mollica, R. (2001). 'Detention of asylum seekers: Assault on health, human rights and social development'. The Lancet, 357 (May), 1436-1437.
38. Amnesty International French Medical Commission, & Marange, V. (1989). Doctors and Torture: Resistance or Collaboration?. London: Bellew Publishing.
39. Kaplan, I., & Webster, K. (2003). 'Refugee women and settlement: Gender and mental health'. In P. Allotey (Ed.) The Health of Refugees: Public Health Perspectives from Crisis to Settlement. UK: Oxford University Press.
40. Shalev, A.Y., Bonne, O., & Eth, S. (1996). 'Treatment of post traumatic stress disorder'. Psychosomatic Medicine, 58, 165-182.
41. Keane, T.M., Albano, A.M., & Blake, D.B. (1992). Current Trends in the Treatment of Post Traumatic Stress Symptoms. In Basoglu ed. op cit., 362-401.
42. Solomon, Z., Shalev, A.Y. & Spiro, S. et al. (1992) 'The Effectiveness of the Koach Project: Negative Psychometric Outcome'. Journal of Traumatic Stress, 5, 225-246.
43. Stein, D.J, Ipser, J.C., & Seedat, S. (2006). Pharmocotherapy for Post Traumatic Stress Disorder (PTSD). Cochrane Database of Systematic Reviews, 1. Retrieved from < www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002795/frame.html >
44. Smajkic, A., Weine, S., Djuric, T., Bijedic, Z., Boskailo, E., Lew, I.J., & Pavkovic, I. (2001). 'Sertraline, Paroxetine and Venlaxatine in Refugee Post Traumatic Stress Disorder with Depression Symptoms'. Journal of Traumatic Stress, 14(3), 445-452.
45. Paunovic, N., & Ost, L. (2001). 'Cognitive behaviour therapy vs. Exposure therapy in the treatment of PTSD in refugees'. Behaviour Research and Therapy, 39(10), 1183-1197.
46. Cienfuegos, A.J., & Monelli, C. (1983). 'The testimony of political repression as a therapeutic instrument'. American Journal of Orthopsychiatry, 53(1), 43-51.
47. Pope, K.S., & Garcia-Peltoniemei, R.E. (1991). 'Responding to victims of torture: Clinical issues, professional responsibilities and useful resources'. Professional Psychology, Research and Practice, 22(4), 269-276.
48. Fischman, Y., & Ross, J. (1990). 'Group treatment of exiled survivors of torture'. American Journal of Orthopsychiatry, 60(1), 135-142.
49. Ivey, A.E., Ivey, M.B. & Simek-Morgan, L. (1993). Counselling and Psychotherapy: A Muticultural Perspective (3rd edn). USA: Aiylin and Bacon.
50. Wraith, R. (1995). 'Children and personal disaster: Risk and preventative intervention'. In B. Raphael, & R. Burrowes (Eds) Preventative Psychiatry, Elsevier Science, 323-341.
51. Rutter, J. (1994). Refugee Children in the Classroom. London: Trentham Books, London, 93.
52. Hjern, A., & Angel, B. (2000). 'Organised violence and mental health of refugee children in exile: A six year follow-up'. Acta Paediatrica, 89(6), 722-727.
53. Hjern, A., Kocturk-Runefors, T., Jeppson, O., Tegelman, R., Hoyer, B., & Adlercreutz, H. (1991). 'Health and nutrition in newly resettled refugee children from the Middle East'. Acta Psychiatry Scandinavia, 80, 8-9.
54. Miller, K.E. (1996). 'The effects of state terrorism and exile on indigenous Guatemalan refugee children: A mental health assessment and an analysis of children's narratives'. Child Development, 67, 89-106.
55. Almqvist, K., & Broberg, A.G. (1999). 'Mental health and social adjustment in young refugee children 3½ years after their arrival in Sweden'. Journal of the American Academy of Child and Adolescent Psychiatry, 38, 723-730.
56. National Collaborating Centre for Mental Health (2005). Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. London: National Institute for Clinical Excellence (NICE).
57. Burke, A. & MacDonald, G. (1994). 'The former Yugoslavia conflict'. In M. Cranna (Ed.) The True Cost of Conflict. London: Earthscan Publications, 163.

Section 4:
Health concerns of adult refugee clients



FIGURE 4.1 Adult health model for refugee health in Australia — optimal health care outcomes in ten years following arrival

Adult refugee health model for transition to mainstream healthcare in the ten years following arrival

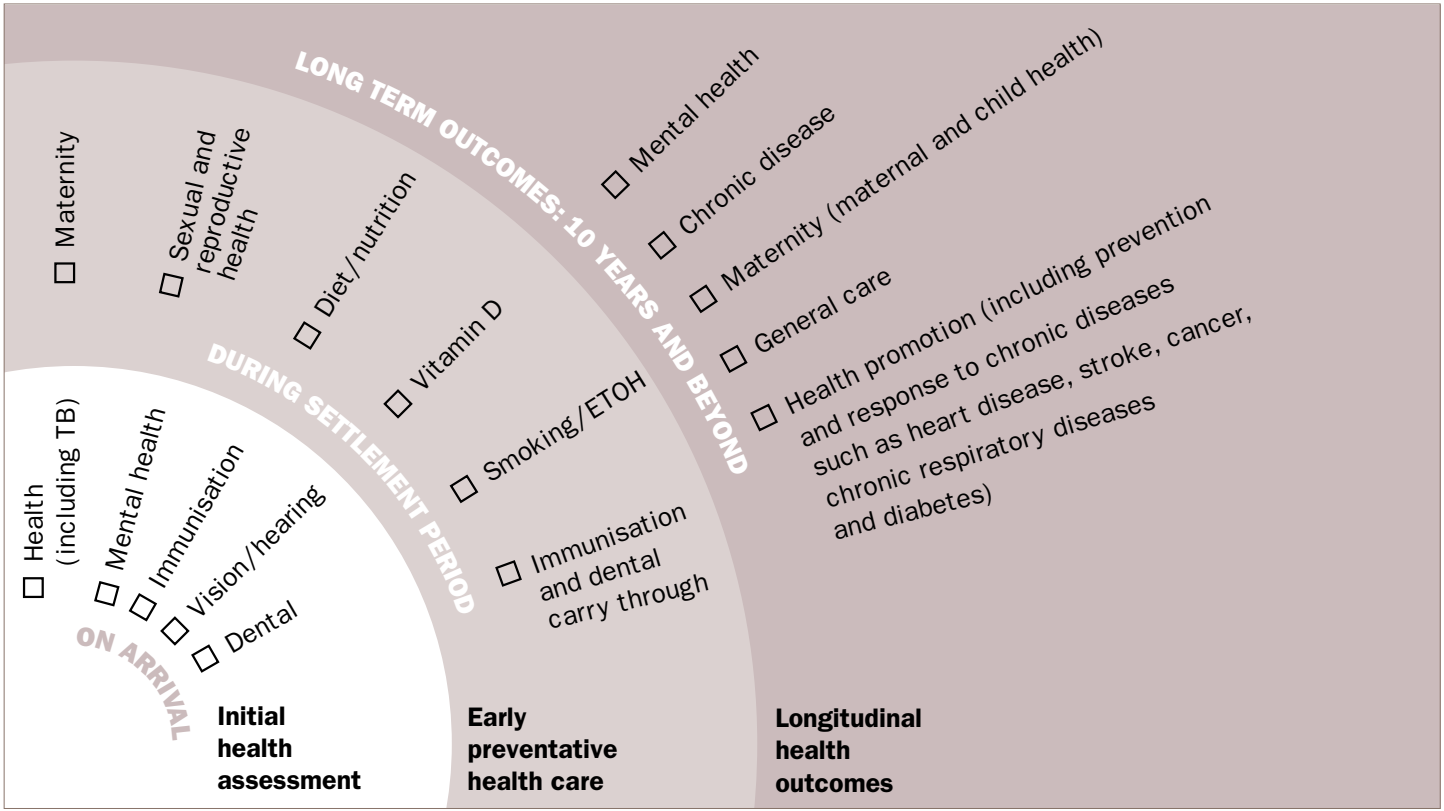


Figure 4.1 shows a long term trajectory to assist refugee clients to transition into mainstream health services in Australia. Initial contact with health services is underpinned by health information and preventative health care. Over time clients are able to increase their knowledge and autonomy over health outcomes by exposure to health information and health promotion activities. This diagram outlines optimal health outcomes for clients of refugee background up to ten years after arrival in Australia.

Initial health assessment and care that addresses immediate health concerns needs to be a starting point for longer term preventative health care such as arranging catch-up immunisation and dental referral and discussing diet and nutrition in the Australian context. This section outlines some key concerns and strategies for improving the long term health outcomes for adults of refugee background.

Common medical conditions

A study of newly arrived refugees attending a Darwin refugee primary health service conducted in 2009 and 2010 found that the most common diagnoses confirmed by testing were vitamin D deficiency (23% of study), hepatitis B carrier status (22%), latent tuberculosis infection (LTBI) (18%), schistosomiasis (17%) and anaemia (17%). Other common conditions indicated in the same study were strongyloides and dental disease.[1] Another study, undertaken at the Royal Melbourne Hospital in 2004–2008, showed that of 156 adult Burmese refugees presenting some 80% were affected by Helicobacter pylori infection. Other prevalent conditions were latent tuberculosis 70% and strongyloidiasis 26%.[2]

Many of the specific concerns mentioned above will be covered later in this section.

Women's health concerns

Some common concerns for women of refugee background presenting in primary care settings include the sequelae of fractures, injuries as a consequence of torture, assault, flight or accident, rape with associated physical and psychological consequences and gynaecological problems (e.g. amenorrhoea, dysfunctional uterine bleeding, sexual dysfunction). Pelvic pain is fairly common, and almost all women will not have had any preventive screening such as Pap smears, breast examination or mammography.

Contraception

Family planning issues for refugee clients may be different to those of other clients. Men and women may have been exposed to varying degrees of information regarding contraception in their home countries or in other places they have lived. As with all clients, this issue needs to be dealt with sensitively. Take into account the client's knowledge, as well as their religious and cultural preferences. It is important not to make assumptions about what these are.

Consider:

- sensitivity of women discussing contraception with men present
- gender of interpreter
- sensitivity to family's attitudes to having any/more children
- some cultures require agreement from the husband for contraception
- some cultures practice abstinence post birth
- contraceptive prevalence and family planning programs/ resources are usually low in countries of origin and transit and many families may be unfamiliar with family planning
- as chemical and barrier methods are prohibited in some cultures, consider the need to refer women to services providing natural family planning advice
- termination of pregnancy may be a difficult issue for religious and cultural reasons.

Breast and cervical screening

In some of the countries from which refugee women originate, there are no established breast and cervical screening programs. In other places, women's access to these may have been disrupted as a consequence of conflict and the refugee experience.

If the client is asymptomatic, consider allowing some time to develop trust and rapport prior to offering mammography or a Pap smear. Consider the possibility that such procedures may be unfamiliar, traumatic or distressing. Book an on-site female interpreter if possible and give detailed information about Pap smears prior to proceeding. Clear information on breast and cervical screening should be offered, written in the client's own language if possible. For information in client languages please see Section 10. A follow-up appointment should be offered. Male GPs might consider referral to a female doctor or nurse. For information on performing Pap smears with women who have undergone female genital mutilation, see Female Genital Mutilation (p.87).



"A GP in Melbourne was giving a talk to a lively and confiding group of 20 Sudanese women, most of whom had been in Australia for 1–2 years, and most of whom had their own GP. Some women were cuddling their infants. The GP was surprised to learn that none of them had been offered a Pap smear and that most did not know what it was."

Pre-pregnancy screening

Due to the many (potentially complex) medical needs of refugee clients, it is worth actively inquiring about the possibility that individuals may be either pregnant or planning pregnancy (or at least, not actively preventing pregnancy), in which case a comprehensive antenatal screen should be offered. For women of child-bearing age, include a routine antenatal screen (FBE, blood group and Abs, ferritin, hepatitis B, hepatitis C, syphilis, rubella, vitamin D, HIV with pre-test counselling, MSU and Pap smear). Add thalassaemia screen including HbS (ß thalassaemia screen may be negative if the client is iron deficient). Genetic counselling may be required.

A sensitively conducted Pap smear, bimanual and breast examination by an experienced female practitioner may be immensely reassuring to women, especially those who have suffered sexual assault.

Address nutritional issues pertinent to conception, such as folate (500 mcg daily) and vitamin D supplementation to help prevent neural tube defects, calcium and iron intake.

If commencing an immunisation catch-up schedule, counsel women about avoiding pregnancy until completed or at least 4 weeks after last immunisation. Contraception may be required.

Antenatal care

Many refugee women will have had minimal exposure to formal hospital-based antenatal care. Previous deliveries may have taken place at home, often with the assistance of a traditional birthing assistant. Members of the extended family may have had a pivotal role in the postnatal care of mother and baby. Certain traditional foods or practices that may be difficult to access in Australia may be thought to be necessary in both the antenatal and postnatal period.

Many refugee women may not be familiar with the options for antenatal care and birth available in Australia, such as birthing centres and shared care. Clear explanations of these options will help women to choose care with which they feel most comfortable. A number of major hospitals provide special multilingual services to women from culturally diverse communities. Health and settlement workers have an important role in supporting women from refugee backgrounds to access hospital antenatal care that is sensitive to their special needs.

The antenatal period is an opportunity to discuss plans for the birth of the baby and preparation for the initial postnatal period. Establishing links and networks with appropriate support services can offer refugee women the advice, guidance and reassurance they require.

It is important for midwives and doctors to establish, in some detail, a pregnant woman's past obstetric history and assess her for general and specific risk factors, to ensure appropriate briefing to the maternity hospital, and support for the client. Refugee women may have higher-risk pregnancies owing to some of the following factors:

- multiple spontaneous or elective abortions
- previous still birth
- neonatal death
- multigravida
- short spacing intervals between pregnancies
- female genital mutilation (see Female Genital Mutilation, p.87)
- recurrent UTI (possibly associated with female genital mutilation)
- pelvic infections (endemic, seldom treated, or resulting from sexual assaults or complications of FGM)
- pregnancy weight <45 kg
- anaemia <10 g/dh sickle cell disease, thalassaemia
- psychosocial issues.

Women may also have complications related to nutritional and vitamin D deficiency, and infectious diseases such as schistosomiasis and latent TB.

Women will benefit from discussion about the benefits of breastfeeding and local services that can offer support if required.

Considerable sensitivity needs to be exercised in discussing previous pregnancies. Negative outcomes may have been associated with extreme physical and psychosocial hardship and therefore be painful to discuss.[3]

Routine antenatal screening should be offered to refugee women (including establishing hepatitis B status and rubella immunisation status). Consider screening for chlamydia in all women (those who are victims of sexual assault; presenting late or no pregnancy care; under 20 years of age). Ensure HIV screening occurs. Although women may have tested negative in pre-arrival screening, they may have subsequently contracted HIV. See Pre-pregnancy screening (p.83).

Genetic screening tests should be offered to all women. These test include ultrasound; nuchal translucency ultrasound combined with Maternal Serum screening (MSS) blood test or second trimester MSS. These tests can determine an increased risk of Down syndrome, Trisomy 18 or a neural tube defect. Chorionic villi sampling and amniocentesis are diagnostic tests not routinely offered but are available to those who have increased risk on screening, predisposition to genetic anomalies or advanced maternal age.[4] Be aware of the costs involved in genetic screening. Many women of low income cannot afford the costs if performed outside a hospital setting. Extra care should be taken in ensuring the purpose of such genetic screening is explained using an appropriately qualified interpreter. For information on working with interpreters see Section 2 > Cross-cultural communication (p.31).

Midwives and doctors are advised to remain alert to signs and symptoms of psychosocial and medical risk factors throughout pregnancy. Issues such as domestic violence, homelessness or obstetric complications should be referred to an appropriate service or clinician.

> “So we are talking about people who have had kids before but are not used to the health system. They think, ‘Why do I have to come to these [antenatal] appointments, what’s the point, you know, I am a healthy person. I don’t have any problems, three of my kids are born naturally,’ and so it’s teaching the whole idea about why you have to come to these appointments.”
>
> — Community worker[5]

PRACTICE TIP

Recognising that some Karen women were not receiving antenatal classes, ISIS Primary Care in Wyndham (Victoria) initiated a 'Karen Pregnancy Classes' program. These classes are run at the ISIS Community Health Centre in Hoppers Crossing. The classes started in 2009, and by 2011 the centre found itself running three series over the year. A four-session series has now increased to five sessions. The five sessions that were run in 2011 focussed on: 1) pregnancy care 2) labour, birth and breastfeeding 3) tour of local Hospital WMH 4) post birth: maternal and child health nurse, mother and baby care, postnatal check-ups 5) postnatal contraception, baby safety, transport, Pap tests and physiotherapy. All sessions are delivered with the assistance of a female Karen interpreter and are free. Information on the topics is distributed in the Karen language and a pictorial leaflet of 'What to take to hospital' has been developed. Karen community members are very appreciative of this initiative. Similar programs, run by bicultural workers have also been successful – demonstrating that classes can also be conducted in the clients' first language if interpreter costs are prohibitive.

Postnatal care

Cultural and settlement factors in delivering care may involve considering the following points.

- Due to the lack of social supports usually offered by extended family and community, the experience of the postnatal period may be very different in Australia for women, even if they have had many previous pregnancies
- In some refugee communities, women and their infants practise a period of confinement in the home after birth (commonly 40 days).
- Be alert to feelings of isolation and depression; refugee background women are in the high-risk group for postnatal depression.
- Home visits may be necessary during this time.
- Practical support facilitates trusting relationships with health professionals. Helping with filling in paperwork for Centrelink or birth registration details may be required.

Maternal and child health (MCH)

MCH provides a comprehensive and focussed approach for the promotion, prevention, early detection, and intervention relating to the physical, emotional or social factors affecting young children and their families. Health checks are carried out on children from birth to preschool age. Checks can be conducted at health clinics across Australia. Note that infants who have arrived in Australia may require referral to MCH services.

The Healthy Start for School Initiative/Healthy Kids Check is conducted at health clinics or by local doctors, between 3½ and 6 years of age. The check includes an assessment on the child's health, growth and development and will help with early identification of life risk factors and development delays and conditions.

Older women and menopause

Consider signs and symptoms of menopause when taking a history from women over 45 years. Although settlement and adjustment to life in a new country can cause mental health concerns that require appropriate referral and/or treatment, menopausal symptoms can sometimes be masked or mistaken for early settlement adjustments and mental health issues.

Older women will require education about the changes that occur post-menopause and how to maintain health and wellbeing in this period.

Many women experience gynaecological problems that affect health and wellbeing. These include:

- menorrhagia
- uterine prolapse
- pelvic pain (infections or problems related to childbirth that have never been addressed)
- incontinence.

Older women may experience disruption to their role as grandmother or matriarch due to family separation or death of family members or caring for grandchildren due to death of parent (their own child) or inability of parent to care for child.

PRACTICE TIP

An experienced Refugee Health Nurse in Melbourne found that older women (over 55 years) of refugee background often believe they are at the end of their lives and that their health is not an important priority. Because of such beliefs, some women may be reluctant to, or rarely seek, medical treatment for health concerns. Women from a refugee background have often come from countries where their life expectancy can be as low as 44 years (Afghanistan for instance). This should be considered when consulting with some middle-aged and older women.

RESOURCES

Centrelink www.centrelink.gov.au/internet/internet.nsf/individuals/healthy_start_school.htm.

DEECD website www.education.vic.gov.au/ecprofessionals/mchnurses/default.htm.

Female Circumcision www.thewomens.org.au/Femalecircumcision.

Australian Breastfeeding Association www.breastfeeding.asn.au.

RESOURCES FOR CLIENTS

Family Planning NSW www.fpnsw.org.au.

Multilingual factsheet on contraception and family planning www.fpnsw.org.au/index_nes.html.

Jean Hailes Foundation www.jeanhailes.org.au.

NSW Department of Health Having a Baby (2006) provides comprehensive information for pregnant women including useful diagrams, healthy eating tips and what to expect at the hospital. It is available here: www.health.nsw.gov.au/pubs/2006/having_a_baby.html.

Female genital mutilation (FGM)

Prevalence

While it is not known how many women in Australia are affected by FGM, it is widely practised in a number of African and Middle Eastern countries from which Australia draws a large proportion of its humanitarian intake. The World Health Organization defines FGM as comprising 'all procedures which involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons'.[6]

Types

There are four different types of FGM, and these classifications can be accessed at the World Health Organization (WHO) website www.who.int/mediacentre/factsheets/fs241/en or the Royal Women's Hospital (Melbourne) FGM website: www.thewomens.org.au/uploads/downloads/HealthProfessionals/FGM/FGM_Health_Professionals_Fact_Sheet_2009.pdf.

Complications

While many women seem to continue their life normally despite having experienced FGM, some women experience long-term complications. These complications can be serious and may include:

- incontinence
- obstructed miscarriage and childbirth
- vaginal and perineal damage at childbirth
- sexual difficulties including non-consummation and painful intercourse.[7]

Other complications include: vulval scarring and pain, pelvic and urinary tract infection, obstructed menstrual and urinary flow, and urinary and faecal fistulae.

Research on the psychological effects of FGM is limited. It has been noted that these may include reactions to trauma of FGM, anxiety and depressive symptoms and effects on sexuality.[7] However, there is no consensus as to whether these sequelae are attributable to FGM or to migration and settlement issues (e.g. the reactions of host communities, intergenerational issues).

PRACTICE TIP

An experienced GP was performing the first Pap smear on a Horn of Africa woman, resident several years in Australia and married with two children, who had experienced infibulation as a child. The client was tertiary educated and spoke excellent English. However, just at the beginning of the smear, the client had a flashback to the moment of FGM at the age of 6 years, experienced intense anxiety, and was unable to continue the examination. This experience shocked her and surprised the GP. However, after discussion she was able to return some weeks later and complete the procedure without difficulty.

Consulting with a woman affected by FGM

Antenatal care

Women affected by FGM often require special care antenatally, during childbirth and in the postnatal period. There are a range of issues that doctors and midwives need to be aware of so that appropriate care can be planned in advance. For instance, some women may be unfamiliar with the Western medical approach to childbirth and antenatal care and may perceive these approaches as inappropriate from cultural and/or religious perspectives.

Antenatally, a key issue is whether it is possible at a minimum to perform a single-digit vaginal examination. If not, then consideration should be given for a minor procedure to 'open up' the circumcision. This needs to occur antenatally rather than leaving this issue to delivery where vaginal examination will be necessary.

Be aware that the need to resuture post-delivery is an area of major concern for some women. Discussing this during the antenatal care period can assist in avoiding this being an issue immediately post-delivery, when relatives may be present and may influence or pressure the woman. Different hospitals, health institutions and states have differing views on resuturing. These views centre on a debate as to whether resewing is considered as reparation to a laceration or as redoing FGM.

If inadequate care is provided at time of vaginal delivery, women may choose to return to their home country for corrective surgery with the baby, thereby risking the baby to FGM procedures.

Surgical revision of infibulation

Women may present to their doctor requesting reversal of infibulation (deinfibulation), since this is a routine sequel to infibulation for most women (e.g. prior to marriage). Again, there are a number of factors that will need to be taken into account in providing appropriate care to this group of women.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) strongly recommends that women requiring deinfibulation be scheduled as an urgent case rather than be placed on a waiting list for this surgery as a non-urgent case.

It may beneficial to refer the client to a doctor or midwife who has experience and training in assisting women who have undergone FGM. In some states and territories deinfibulation clinics exist.

KEY POINTS

Counselling and support

- Be sensitive to the possibility that the woman may wish to discuss issues associated with FGM. However, avoid raising the subject where there is no apparent reason to do so.
- Health practitioners who are familiar with the issues are well placed to provide counselling and support to women affected by FGM where this is required.
- Recognise that women may be unaware that there are medical complications associated with FGM or that specific complications experienced by them are related to FGM.
- Explore and respect the woman's wishes.
- Expect that women may experience some difficulty in discussing matters associated with FGM.
- Use the terms 'cutting', 'traditional surgery', and 'traditional' female circumcision until the woman's preferred term is identified.

KEY POINTS

Gynaecological examination of women with FGM

- Consider referral to a female doctor.
- Be aware that this may be the woman's first experience of the Australian medical system and that she may not have previously had a gynaecological examination.
- Be aware that pelvic examination may be difficult, painful or impossible, and do not persevere if unduly uncomfortable or painful – use of small speculae, careful angulation of instruments and single-digit examination may be necessary.
- Document findings in detail to minimise the need for repeat examinations and so that future difficulties such as catheterisation problems can be anticipated and planned for.

Adapted from the Royal Australian College of Obstetricians and Gynaecologists (RANZCOG) (1997) Female Genital Mutilation: Information for Australian Health Professionals http://www.ranzcog.edu.au/publications/womens-health-publications/female-genital-mutilation-fgm-booklet.html.

Cultural issues and culturally sensitive approaches to care

FGM is motivated by complex sociocultural factors and is performed as a matter of social convention believed to protect young women from social, cultural and economic ostracism.

Be aware of some communities' sensitivity regarding nomenclature of the practice. Although FGM is the WHO-preferred term, appropriate terminology to use during consultation may be 'ritual', 'traditional' female circumcision, 'cutting' or 'traditional surgery'. Some women do not consider FGM as surgery.

Some women may want their daughters to undergo FGM, even if this means undertaking the operation outside Australia. This may pose a dilemma for those professionals who are committed to respecting the client's cultural practices, while at the same time being concerned about the practice of FGM and their legal obligations.

Australian law

All Australian states and territories have specific legislation prohibiting FGM.[8] In most Australian states and territories, there is a commitment to prevent FGM through a two-part strategy involving education and legislation. In those states where healthcare professionals are mandated to report child abuse under child protection laws, this requirement usually applies where FGM has recently been performed, or where a child is believed to be at risk (whether it is anticipated that it is to be performed in Australia or elsewhere). For further information contact the child protection service line in your state or territory. See Section 11 (p.323).

Education

Health professionals may be in a position to assist in preventing the practice of FGM by explaining its negative health implications. This is particularly important since the practice is often supported in affected communities in the mistaken belief that it has health benefits for women.

The Family and Reproductive Rights Education Program (FARREP) is a Victorian education program on FGM. It aims to provide culturally appropriate intervention to prevent the occurrence of FGM in Australia and to assist women and girls living in Australia affected by this practice. Establish contact with the network through the office of the Manager, Integrated Health Promotion, Department of Health Victoria.Family Planning Victoria provides accredited sexual and reproductive health training to GPs and nurses, which includes FGM. For further information see website www.fpv.org.au.

RESOURCES

An extensive number of fact sheets and other publications have been developed by the Royal Women's Hospital in Victoria and Women's Health West, for health practitioners working with African women during pregnancy and childbirth. The fact sheets include issues and information to consider when working with women and young women affected by FGM. The fact sheets are available at these two sites: www.thewomens.org.au and www.whwest.org.au/docs/MN2s3.pdf.

Men's health concerns

For many new arrival communities, the role of the man has historically been that of decision-maker, provider and 'head of household'. Some men find it difficult to adjust to new expectations and the new freedoms of their wives and children (especially daughters) when they arrive in Australia. Many refugees have lived for long periods in very violent times, often fighting for their lives for extended periods. This can lead to a skewed vision of what constitutes 'violence' and what is 'normal'. While there is little reliable data, anecdotally service providers report high levels of domestic violence among refugee communities. It is important to consider boys as potential targets of such domestic and sexual abuse.

Although the health of refugee men remains under researched, there is some evidence that refugee men's health can be broadly understood by the intersection of particular refugee health concerns and general men's health issues. The following health issues have been identified among refugee men.

Physical health

Refugee men, like their female counterparts, may also suffer from war- and torture-related injuries, including the physical effects of sexual torture. Other physical health problems may also include poor dental health, diseases associated with long-term exposure to the elements and poor diet, as well as chronic conditions such as hypertension, diabetes and obesity.[9, 10]

Loss of identity

Identity issues associated with loss of social, socioeconomic and occupational status, lack of recognition of prior qualifications, and changes in gender roles are common problems among refugee men.[11] Loss of identity can lead to low self-esteem, depression, long-term unemployment, substance abuse, domestic violence and family breakdown. Refugee men see the exclusion of the extended family and community leaders as a serious shortcoming of the Australian approach to dealing with domestic disputes, and experience confusion over new expectations regarding parenting/fathering roles.[10, 12]

"Prior to the family coming to Australia, the man was the source of income and the wife was depending on the income of her husband. The husband had the authority. When the family comes to Australia, the husband and wife are almost the same. The authority of husband gets lost. This creates complexities."

– Eritrean husband

"The difference between Afghan culture and Australia culture is so wide, so it's hard to bring them together."

– Afghan man

Sexual health and behaviour

The most important underreported and undiagnosed health issue for refugee men may relate to the physical and psychological impact of sexual torture. See Section 3 (p.45). Other important sexual health issues to consider are as follows:

- Male circumcision is widely practised in some countries, and is part of the rite of passage into adulthood in many societies, such as Muslim societies and many African cultural groups.
- Often men would prefer to see a male GP if there are any sexual problems or concerns.
- Counselling and education support needs to be given to male partners of victims of family or sexual violence.
- Some communities and religions have traditionally had a lack of access to condoms and stigma associated with their use, yet teenagers and adult men may be sexually active, needing regular advice on safe sex practices as well as screening for STIs.
- In some cultures, the age of consent is different from that in Australia; thus it may be advisable to discuss Australian practices and laws concerning sexual relations including age of consent. Australian laws vary between states and also according to the gender of sexual partners.

Family planning agencies provide education services in schools and may have suitable resources available.

Approach to health care and counselling

The provision of services to refugee men may be limited by barriers to access such as a lack of knowledge about available services, difficulties in developing trust, and reluctance to seek help or disclose a history of torture and trauma. Structural barriers such as out-of-pocket consultation costs, transport costs and employment commitments may also impede access to services. Many men can show a reluctance to admit they are not coping, or acknowledge that post-traumatic stress may be the cause of their anxiety or their depressive or somatic symptoms. They may be hesitant to participate in counselling due to stigma associated with mental health problems, so care is needed in explaining a referral for counselling or assessment. Group approaches that are activity-based and get men talking to each other in a non-threatening environment can sometimes be a way of reducing barriers to talking about problems they are facing in adjusting to Australian life. For some, religious/spiritual guidance or rituals such as prayer may be beneficial.

Substance abuse

There is limited information documenting the patterns, causes and consequences of licit and illicit drug use among people of refugee background in Australia. A 2005 study examining the prevalence of substance misuse among refugee groups reports that the stresses such as trauma, loss, adjustment and disadvantage, place refugees at an increased risk for substance misuse.[13] Health practitioners report that the high rate of previous traumatic experiences in the homeland, refugee camps, while living in precarious circumstances, urban areas and during resettlement is associated with substance misuse.

Drugs may be used for symptomatic relief when the effects of war, terror, torture, rape, imprisonment and physical injury become overwhelming. Alcohol, cannabis, heroin and other substances may be used to calm the anxiety associated with the memories of past trauma, including the post-traumatic stress disorders that occur within refugee populations. Some may use drugs prescribed for another person or take large amounts in an unmonitored way. Some cultures chew certain leaves and nuts that may interact adversely with other drugs such as stimulants.

The stresses associated with resettlement and limited access to services can lead to feelings of depression and anxiety, and thereby increase susceptibility to substance misuse.[14] Substances may be used to cope with the distress, and a lack of family cohesiveness and social support.[15]

Younger people may use or sell drugs such as amphetamines to give them energy, or ecstasy as a superficial symbol of joining a new culture. Unemployment and social isolation can be significant factors related to young people selling drugs where there are few economic alternatives.

For some refugee groups there are difficulties accessing services. There may be shame and stigma associated with seeking help for mental health issues and drug problems, or they may be less likely to seek attention for their emotional or substance misuse issues.

A more lenient attitude towards alcohol and drugs as well as their relative availability in Australia, can result in increased use. There is also a need for provision of more information in community languages about the risks associated with drug and alcohol use as well as the need to ensure that treatment services are responsive to refugee populations.

The Drug and Alcohol Multicultural Education Centre http://directory.damec.org.au/ is a gateway to drug information targeting culturally and linguistically diverse communities.

Oral health

Prevalence

Assessment of oral health is particularly important for clients of refugee and asylum seeker background, with reports indicating high levels of untreated caries or dental decay.[16, 17, 18] A study conducted between 1978 and 2005 comparing the oral health status of refugee groups in Australia to the general population, to Indigenous Australians and to special needs populations reported that the dental health of refugees (particularly untreated decay) compared poorly with the comparison groups.

> Of the 4,923 people assessed by the Victorian Foundation for Survivors of Torture in Melbourne between 2009 and 2011, 17.2% required referral for dental treatment that ranged from minor restorative work to substantial specialist care. Some client groups from particular countries had a much higher rate of dental care need of up to 36.4% [19]

Factors affecting oral health

PRE-ARRIVAL

Though dental health varies among different refugee populations, factors related to the refugee experience that impact on oral health include poor diet, inadequate conditions for dental hygiene, lack of access to water fluoridation, lack of dental care and exposure to severe injury to the teeth and gums in the course of torture.[20] Various ethnic groups remove or file teeth as part of traditional body modification practices or traditional healing.

POST-ARRIVAL

Other factors to take into account include:

- oral health literacy including unfamiliarity with the Australian dental care system and procedures and understanding of preventative health messages[16, 20 21, 22]
- availability of sugar-rich food items following arrival in Australia
- dental care may not be seen as a high priority by refugee clients during the resettlement period
- culturally specific dental hygiene practised by some people is different to oral health care in Australia
- language barriers (e.g. inability to access resources and care).

Access to dental health services remains a significant problem due to the high cost of private care, poor referral processes to and between dental care services, and long waiting lists for public dental care in some states. This may lead to people seeking care only when problems are advanced.

PRACTICE TIP

Survivors of torture may find dental treatment a painful reminder of past experiences and may require additional support and a particularly sensitive approach. Past experiences might include the use of tooth extraction as a form of torture, sexual assault, and use of harsh lights during interrogation and for the purposes of sleep deprivation. Dental instruments being put in the mouth may trigger memories of a gun.

Common clinical presentations

Acute dental presentations to general practice are common such as abscesses and gingivitis. Other common oral health problems for patients of refugee background include:

- dental caries
- periodontal diseases
- malocclusion
- orofacial trauma
- missing and fractured teeth
- oral cancer[16, 21]

Referral

In Victoria, people from refugee and asylum seeker backgrounds have now been identified as a priority access group, providing fee exemption and next available appointment for general and denture care.[23, 24]

Emergency, routine and some specialist oral health care is available to those holding a Health Care Card through public dental clinics at public hospitals and, in some states and territories, community health centres. Specific dental programs for refugees or priority access through public programs are often limited by a lack of resources and strict selection criteria.[16] In most states and territories, people must be registered with Medicare in order to qualify for care. However, Victoria and the ACT provide access for asylum seekers, including those without Medicare cards.

When referring clients to or between dental services, it is helpful to explain the dental system and introduce clients to assessment, treatment and referral protocols. Clients who are unfamiliar with these protocols may otherwise be confused if they attend their first appointment expecting all treatment to be undertaken in one session. It is useful to send any available information such as social and medical history. A systematic review undertaken in Canada specific to refugees showed that people are twice as likely to go for dental treatment when they are actively examined and referred by a physician.[18] For information on public dental services contact the dental health service in your state or territory. See Section 11.

Health promotion – oral health

Doctors and healthcare professionals in both private and community settings play a role in enabling people to increase control over, and to improve, their health. In 2011 the Victorian Government produced a summary document of effective strategies for health promotion, including strategies for oral health promotion with people of refugee-like backgrounds. Key messages for oral healthcare are identified as:

- diet (tap water, limiting intake of sugary foods)
- twice-daily tooth cleaning
- accessing dental health services.[25]

Some successful approaches to oral health promotion are identified as:

- using culturally appropriate resources in partnership with communities
- explaining bilingual resources and allowing time to ask questions
- raising awareness of oral health issues at community days, fairs, community health centres and in medical practices
- using childcare forums, maternal and child health centres and English training sessions to talk about oral health.

For oral health resources in a range of community languages see Section 10 (p.309).

EASTERN ACCESS COMMUNITY HEALTH COMMUNITY DENTAL CLINIC, VICTORIA

As part of the initial refugee health assessment, Refugee Health Nurses (RHNs) at the Eastern Access Community Health community health centre in Melbourne's outer eastern suburbs refer clients who need dental care to the centre's community dental clinic. The nurses provide as much referral information as possible via their TRAK referral system or email notification. If at the time of the health assessment pain is noted, the case is marked as an urgent referral. If no immediate pain is detected a regular Priority Access appointment is arranged. On-site interpreters are also arranged.

If the client is a child, they are prioritised and care is taken to make sure they are comfortable (double booking for siblings, family member present, on-site interpreter). Any newly arriving refugee women who are pregnant are prioritised for dental care as a preventative measure to check their oral health and share advice on dental care and pregnancy.

After their initial dental appointment, many clients are then clinically prioritised for a full course of care and ongoing appointments are made to complete their needs. Follow-up treatment occurs with the majority of clients from refugee background as most have had very little, if any, dental care before arriving in Australia.

Some clients of refugee background also then need to receive specialist care, which is organised by referral from the community centre to specialists such as Endodontic and Periodontists as gum disease is common. Many refugees particularly from Burma have advanced gum disease. A number of young people have had referrals to the Royal Melbourne Dental Hospital for Orthodontics, where they receive otherwise unobtainable orthodontic care. This is a major factor in social acceptance and confidence and to have a happy, confident smile. Many clients have had very poor cleft repairs overseas and establishing priority of dental care has meant that many have been referred for much appreciated intensive reconstruction work in plastic surgery and dental implants.

As part of the centre's support to the refugee community regular education days are held for mothers on healthy eating and home dental care by the dental team; these include 'take home' supplies and instruction on tooth brushing and infant care. EACH also provides space for community meeting spaces for parents. Integral to the functioning of this oral health care are attitudes of respect, equality and providing support and education in their health and wellbeing.

This program came about in recognition of the growing numbers of people of refugee backgrounds settling in Melbourne's outer east. To date, the initiative has been entirely funded with existing resources.

RESOURCES

The NSW Refugee Health Service has developed a number of factsheets to assist community workers and dental professionals to work with people from refugee backgrounds, and asylum seekers. Fact Sheet 10 Dental Health of Refugees: for Community Workers to assist community workers to make referrals to dental services is accessible here: www.sswahs.nsw.gov.au/sswahs/refugee/pdf/Resource/FactSheet/FactSheet_10.pdf. Fact Sheet 11 The Oral Health of Refugees – for Dental Professionals can also be accessed online via the NSW Refugee Health Service website: www.sswahs.nsw.gov.au/sswahs/refugee/pdf/Resource/FactSheet/FactSheet_11.pdf.

Vision

Refugee clients have typically had poor access to health services for eye care and treatment. Routine, culturally appropriate visual screening, especially for children, is recommended. Prevalent conditions in the countries of origin and transit of refugee clients include trachoma, cataract and glaucoma. Common eye problems may be caused by:

- refraction errors
- vitamin A deficiency
- infective causes, including trachoma or parasites
- inflammation/allergy
- head injury/beating.

Note: Inflammation may look different in darkly pigmented eyes.

If working in a primary care setting it is worth referring to a bulk-billing optometrist in your area. Organisations and charities that provide free or subsidised eye wear exist in most cities, and care should be taken to explain to patients that they may be eligible to take their eye script to these services rather than paying for eyewear at the optometrist.

Measuring visual acuity – some guidelines

Here are some guidelines for optometrists and hospital health clinics working with clients for whom reading in English may be problematic. Using a suitably qualified interpreter is recommended.

The 'E' Logmar chart is useful if working with clients who are not confident reading or recognising letters. This test uses the letter 'E' in its four different orientations (up, down, left, right) and the patient is required to indicate in which direction the 'E' faces. This is an effective test, and the patient can use their fingers to represent the strokes of the 'E'. Conversely, a large letter 'E' can be simply printed on A4 paper and laminated, and the patient can turn the 'E' to match the 'E' presented on the chart. The Logmar 'E' chart has a consistent decrease in letter size, and can be measured at 6 metres or 3 metres.

The LEA symbols chart is a very effective test, typically used with children to check if they need referral to other vision services. It is also often used with adults. It includes four shapes, a heart (or an apple), a square, a house and a circle, and the patient is required to match the shapes.

If the top letter of the chart cannot be seen, then hold some fingers at 50 centimetres from the patient. This is recorded as CF. If fingers cannot be counted, try moving the hand at 50 centimetres, which is recorded as HM. If hand movements cannot be seen, then shining a torch light into the eye is recorded as LP (light perception) or NLP (no light perception).

PRACTICE TIPS

- Whichever chart you have, printing up a letter-matching card is invaluable.
- Get the patient to read the letters down one side from the top, rather than all the letters across, until the letters become more difficult. At this time get the patient to read across. This can save a lot of time.
- Once you have measured VA in both eyes, use a pinhole in front of each eye. If the vision improves with a pinhole, it suggests a refractive cause of reduced vision, as a pinhole decreases the blur size. If vision doesn't improve with pinhole, this can be suggestive of a pathological cause of reduced vision.
- Be aware that ophthalmological services may be cost prohibitive for some patients, referral to bulk-billing services, or services that offer subsidised glasses, is recommended.

RESOURCES

The Atlas of Ophthalmology is a public ophthalmology database regularly updated by eye specialists. The site includes material in a variety of languages. www.atlasophthalmology.com/atlas/frontpage.jsf

Hearing

The causes of deafness and hearing impairment in refugee clients are similar to that of the wider population. Health services are limited in the countries of origin and transit. Common causes include:

- middle ear infections and effusions
- wax impaction in external canal
- congenital deafness
- head injury and assault
- exposure to environmental noise (e.g. loud explosions).

Clients may be unfamiliar with early testing, prevention and intervention. Therefore it is important to explain the referral process, with an interpreter if required.

As many clients may not have had access to deafness services or education, they may not have a strong command of any officially recognised sign language. Hearing impairment creates an additional barrier when trying to communicate with refugee clients.

The Australian Government Hearing Services Program provides a range of hearing rehabilitation services, free of charge, to any Australian permanent resident aged up to 25 (inclusive) who has, or is at risk of, permanent or long term hearing loss. Some older adults may also be considered. These services include regular monitoring of hearing needs, hearing aid fitting and assistance with maintenance, upgrade and replacement of cochlear implants. Contact Hearing Australia for more information (131 797) and for referral to a local service provider. More information is available on the Hearing Australia website: www.hearing.com.au/info-for-gps> and on the Department of Health website: www.health.gov.au/hear#areas.

Clients can be referred for hearing tests to services in your state or territory. For details see Section 11 (p.323).

Nutrition

Nutritional deficiencies are common in refugee clients, and are usually due to a chronic lack of essential nutrients, including macronutrients (carbohydrates, fats, proteins), micronutrients (minerals, vitamins), antioxidants and phytochemicals.[26] Micronutrient deficiencies are common, affecting an estimated 2 billion people worldwide, with women and children at greater risk.[27]

Common nutritional problems seen in adult patients include:

- concerns about weight gain/loss after arrival in Australia
- ongoing lifestyle and diet concerns (e.g. loss of traditional foods, exposure to high sugar intake)
- vitamin D and/or calcium deficiency
- vitamin A deficiency in lactating and pregnant women
- iron deficiency anaemia.

Factors to consider in nutrition screening

There are a number of important contributing factors to consider when conducting a nutritional assessment with clients of refugee background. These include:

Pre-arrival factors	Post-arrival factors
Poverty and lack of education	Lack of familiarity with Australian foods and how to prepare them
Inadequate food (quality, quantity, variety), for prolonged periods, contaminated water	Lack of access to traditional foods
Parasite infections, H. Pylori and other chronic infections, chronic diarrhoea, malabsorption	Low English print literacy, resulting in difficulty reading labels, written guidelines and dietary advice
Dental problems, which may cause difficulties chewing/ eating	Cultural issues – in some communities it is the women who shop and cook. Unaccompanied men, especially minors, may find shopping/food preparation unfamiliar. Cultural eating patterns should also be considered (e.g. reduced meat intake in women and children; a vegan diet; lack of fresh vegetables; high intake of cooked/stewed food and/or low calcium intake)
Low birth weight and nutritional insult during early childhood	Food knowledge – including food safety (e.g. knowing tap water is safe) and food handling/safe storage
Number of pregnancies	Poverty
Menstruation patterns	Shift work and irregular individual/ household eating routines

Consequences of torture and trauma

A common symptom and side effect of trauma can be poor appetite, including feelings of nausea at the sight or smell of food, being repulsed by food, and being unable to eat anything. Reasons may include the following.

- Feelings of guilt may be associated with eating if concerned about relatives left behind facing food shortages.
- Anxiety may be associated with trauma or due to ongoing problems of resettlement.
- Clients may have conditioned themselves to an inadequate dietary intake as a response to prolonged periods of hunger.
- Food may have been deprived by authorities and regimes as a form of torture or humiliation.
- Eating disorders may be a problem.
- Excessive amounts of coffee and other stimulants such as tobacco are often used as a means of coping with anxiety. Consumption may exacerbate some post-traumatic stress disorder (PTSD) symptoms (e.g. anxiety, sleeplessness) and cause reflux (heartburn).

“

A GP counsellor was concerned to find that one of her pregnant Sudanese clients was encouraging her children to eat less or skip their school lunches so that money could be saved and sent to her relatives, who were living in an unsafe refugee camp in Africa.

Nutritional assessment

- Take a detailed dietary (and general) history and ascertain access to and quantity and quality of food overseas and after settlement. Be aware that malnutrition and food insecurity after resettlement is common in refugee communities, including in Australia, sometimes even for those who arrived years earlier.[28, 29]
- Routine initial refugee health assessment bloods will provide information on anaemia, iron deficiency and vitamin D status, and may indicate organic disease. Test for folate and B12.
- Consider organic disease such as gastrointestinal infections (Helicobacter Pylori, Giardia intestinalis and other parasites), other infections (including TB), low vitamin D/rickets and dental disease (leading to difficulty chewing).
- Body mass index: less than 18.5 suggests risk of malnutrition in adults; this may differ according to musculature and ethnic group. Check percentile charts for children. See Section 5.
- 10% reduction in body weight in 6 months requires follow up[30, 31, 32]
- Low serum albumin suggests chronic protein deficiency (also low in surgery, sepsis, and inflammatory diseases).
- Anaemia is most likely due to iron deficiency, but also consider vitamin B12 in some groups.
- Specific micronutrient deficiencies may need expert assessment and referral. In most cases, dietary advice and a good multivitamin will be sufficient if underlying risk factors have been excluded.
- Address general diet and lifestyle issues.
- Iron deficiency anaemia and vitamin D deficiency are the most common nutrient deficiencies seen among recent arrivals, especially in women and children.
- Refer early to a dietitian.
- Emphasise the need for a balanced diet with a wide variety of fruits and vegetables; the importance of physical activity; avoid junk food and sweetened drinks.
- For newly arrived refugees who have come from refugee camps or situations of dire poverty, provision of a general multivitamin and mineral supplement may be necessary.

For guidance on nutrient assessment for children and adolescents, see Section 5.

“”

A GP working in a busy clinic in Melbourne’s northern suburbs spoke of a family who cooked outside on a homemade barbecue for 6 weeks because they did not known how to use their oven or stove.

Health promotion – nutrition and lifestyle

While clients may not identify eating problems themselves, many healthcare professionals working with refugee clients have noted that adjustment to diet is a significant factor in both physical and psychological health, and relates to integration and autonomy. Many clients have noted that they don't have enough information to make the 'healthy choice' in Australia. Accordingly, it is worth discussing the client's lifestyle and dietary practices during the initial health assessment and on an ongoing basis. Consider offering sensitive advice and strategies about the following.

- **The 'junk food' diet:** Junk food is cheap and readily available, and may be a popular choice for some families, as unfamiliar ingredients can be daunting to prepare and junk food provides a less complicated alternative. Explaining how to read labels and the amount of sugar or 'energy' in fast foods and sugary drinks, as well as the long-term health effects of poor dietary intake, enables individuals to make different dietary choices.
- **Accessing traditional food:** Traditional foods from a person's country of origin are more often than not healthier than many Australian alternatives. Assisting families to identify shops and suburbs where they can buy healthy, familiar, traditional foods and ingredients from their country of origin greatly assists in the settlement process and empowers communities to feel more in control of daily life. Discussing diet and nutrition in relation to these foods if often greatly appreciated by people of refugee background.
- **Physical activity:** Individuals may find that after resettlement in Australia there are reduced opportunities for physical activities due to reliance on motorised transport, lack of familiarity with suitable locations to exercise, fear of walking in the streets and limited time for self-care (particularly for women). Some clients may not be familiar with exercise that is not incidental to daily routine. You may also like to discuss the impacts of physical activity due to unemployment, which might exacerbate feelings of anxiety and depression and could lead to problems of rapid weight gain and obesity.
- **Rapid weight gain and obesity:** Excessive food consumption (particularly foods high in sugar and fat) as a response to prolonged periods of deprivation is not uncommon, and some parents may be unwilling to place restrictions on children's food intake. Depression may also be a significant factor in overeating. It is important to talk about quality and quantity of food to be consumed for a healthy diet.

Addressing general diet and lifestyle issues: a health promotion perspective

GENERAL ADVICE

- Refer to a dietitian as early as practical after arrival in Australia.
- Tap water is safe, fluoridated, plentiful and cheap.
- Provide clients with basic dietary advice.
- Establish the client's experience in shopping for and cooking food.
- Point out the benefits of physical activity for both physical health and the management of anxiety and depression; encourage incidental exercise; if possible, introduce people to both formal and informal exercise opportunities in Australia (e.g. gymnasiums, swimming pools, parks and gardens).
- Encourage dark-skinned women to maximise their skin exposure to sun within cultural traditions. See Vitamin D deficiency (p.110).
- Support breastfeeding mothers and link them into child health services.

CULTURAL FACTORS

- Ensure that advice takes account of cultural patterns in food consumption (e.g. food preferences, the timing of the main meal of the day).
- Consider the following questions:
  - What type of food was eaten when you were ill in your country?
  - What sort of food was eaten for festivals and celebrations?
  - What is your favourite food, and are you able to prepare it here?
  - Are there difficulties in obtaining, preparing and cooking the food that you like here in Australia?

ADDRESSING PSYCHOLOGICAL BARRIERS TO EATING WELL

Clients experiencing persistent psychological barriers to 'eating well' (e.g. anxiety, guilt) may require referral for counselling to address underlying issues. It is important for practitioners to be non-judgemental and to acknowledge the client's difficulties in eating. Asking questions in a general way and avoiding being prescriptive may encourage the client to discuss their problems.

RESOURCES

The Victorian Department of Health Better Health Channel is an online library of health and medical information to help individuals improve their health. The site includes printable fact sheets, pictures and diagrams in plain English. This is a good source of information to give to patients on a wide range of topics. For more detailed information and resources for supporting new arrivals to address diet and lifestyle issues see the Food variety and a healthy diet page (2010): www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/(Pages)/Food_variety_and_a_healthy_diet?OpenDocument

Victorian Foundation for Survivors of Torture (VFST) has created a series of pamphlets entitled Healthy Eating and Living In Australia (2000). The pamphlets include tips on shopping for food, eating well and feeling healthy. The pamphlets are available for download in Arabic, Bosnian, Somali and other languages from the VFST website: http://www.foundationhouse.org.au/resources/publications_and_resources.htm.

Further multilingual health promotion resources are available from The U.S. Committee for Refugees and Immigrants: Nutritional outreach kit (in Amharic, Arabic, Burmese, Farsi, Hmong, Karen, Kirundi, Nepali, Somali, Swahili) web page: www.refugees.org/resources/for-refugees--immigrants/health/nutrition/refugee-nutrition-outreach.html .

The Association for Services to Torture and Trauma Survivors (ASeTTS) in Western Australia has put together a website with nutritional information and factsheets for health care providers and for clients from South Sudanese and Afghan backgrounds. Factsheets include information on traditional foods and where to source them, budgeting for food, preparing food such as school lunches and information on religious food requirements. Access all of this information on the Good food for new arrivals website: http://pubs.asetts.org.au/nutrition/.

Calcium

Prevalence

Calcium intake tends to be inadequate in most of the Australian population, especially young women. Many refugees come to Australia from a situation of food deprivation, and are therefore likely to be calcium deficient. The recommended dietary intake (RDI) is 1,000 mg per day, and 1,300 mg per day for people over 70. Periods of rapid skeletal bone growth in children are also often times of low calcium status.[33]

Common causes

Calcium deficiency is associated with poor dietary intake. Many of the traditional sources of calcium are no longer available to refugees as they acculturate, and many cultures do not use dairy products in the same way as Australians due to secondary lactose intolerance. Therefore, calcium intake may appear to be much lower in refugee clients.

Management

Increased intake of calcium-rich foods such as dairy, green vegetables, fruit, dried nuts and seafood may assist. Calcium supplementation may also reverse the effects of short-term deficiency in some adult clients. Calcium absorption is mediated by vitamin D, and vitamin D deficiency should be considered. Other factors to consider include protein and sodium intake, which both tend to increase dramatically in refugees after arrival in Australia.

Vitamin D

Vitamin D deficiency is widely regarded as a priority area for refugee health care in Australia. This section covers adult health. See also Section 5 (p.195) for information on vitamin D deficiency in children and adolescents. Readers should keep in mind that there are subtle differences between adult and child health care on this issue, and where working with families, doctors and nurses should refer to Section 5 > Vitamin D (p.195).

Vitamin D is essential for bone and muscle health, and there is increasing evidence that it is important for other aspects of health. Low vitamin D causes increased bone turnover and inadequate bone mineralisation, which can end in osteomalacia in adults, and especially women. Vitamin D also plays an important role in the immune system, and deficiency has been associated with a range of diseases, including infections, autoimmune diseases, multiple sclerosis, cancers and cardiovascular diseases. Vitamin D's role in causal pathways in these diseases is currently being studied.

Most vitamin D is made in the skin through exposure to the ultraviolet B (UVB) wavelength of sunlight. The amount of UVB available to skin for synthesis of vitamin D varies with latitude, season, time of day, shade and skin exposure. Window glass blocks UVB. Estimates suggest that 10 minutes per day for light-skinned people is needed to obtain sufficient vitamin D in summer in northern Australia. Darker skin requires at least three or six times this amount of sun exposure in order to synthesise the same amount of vitamin D.[34, 35]

Diet is a poor source of vitamin D for most Australians. Generally, only 10% of the body's requirements for vitamin D is obtained through diet (e.g. fatty fish, liver, eggs, fortified margarine and some low-fat milks), so it is impossible to meet normal vitamin D requirements through diet or to treat deficiency states through diet alone.[31, 36]

Breast milk has little vitamin D, so babies born to vitamin D deficient mothers are at increased risk of rickets.[34] See Section 5 (p.195). Pregnant women at risk of deficiency should be screened and supplemented. Women of child-bearing age may also benefit from vitamin D counselling if considering pregnancy.

Prevalence

Vitamin D deficiency is very common among refugee groups in Australia, as it is within the Australian-born population. Australian studies have found 61–100% in African refugees in Melbourne, Adelaide and Sydney have low vitamin D (<50 nmol/L)[36, 37, 38, 39, 40, 41] and Australian and New Zealand studies have found 60–80% of veiled and/or dark-skinned women attending antenatal clinics have levels less than 25 nmol/L.[42, 43, 44] Low vitamin D is also seen commonly in other refugee cohorts wearing covering clothing (Afghani, Iraqi), and has also been found in 33% of Karen refugees.[45] Tiong et al. demonstrated that 29% of newly arrived African refugees had levels of less than 37 nmol/L.[46]

Groups at risk of low vitamin D include:

- People who do not expose their skin to sunlight or who spend most of their time indoors
- People with naturally dark skin
- People with conditions affecting vitamin D metabolism (e.g. malabsorption, obesity, liver/renal disease, medications including rifampicin)
- Babies born to women with low vitamin D
- Exclusively breastfed babies with other risk factors

Common causes of vitamin D deficiency

In the refugee population, vitamin D deficiency is mainly due to insufficient sun exposure. Risk factors include dark skin, wearing clothing that covers arms, head or face and limited time outside in the sun.

Clinical picture

Vitamin D deficiency may be asymptomatic or be associated with non-specific bone pain, muscle pain, poor exercise tolerance and fatigue. Consider rickets. Very low vitamin D levels may cause symptomatic hypocalcaemia (stridor, tetany, seizures) (see Calcium, p.110); this is more common in infants <6 months.

25-hydroxy vitamin D (25(OH)D) is used to measure vitamin D stores. The recommended level for serum 25(OH)D is ≥50 nmol/L (at all ages and during pregnancy). Definitions of vitamin D status are outlined in Table 4.1.

TABLE 4.1 Serum 25(OH)D levels

Definitions of vitamin D status		Possible symptoms on presentation
Severe deficiency	<12.5 nmol/L	Causes osteomalacia. Clients with severe deficiency may present with bone and muscle pains, weakness and pseudofractures, or fractures with minimal trauma.
Moderate deficiency	12.5–29 nmol/L	Clients frequently describe aches, pain and some muscle weakness.
Mild deficiency	30–49 nmol/L	May be asymptomatic, or there may be some complaints of arthralgia and bone pain.
Sufficient	≥50 nmol/L	
Elevated	>250 nmol/L	

Screening

- Screen all newly arrived refugees, especially those at risk (those who have darker skin, who have little exposure to sunlight due to dress or who are housebound).
- In particular, screen refugee women who are pregnant, planning pregnancy or breastfeeding.
- Recheck vitamin D levels in those previously deficient during winter months.
- Check renal function

Management

- Use vitamin D3/cholecalciferol (which may raise serum 25-hydroxy vitamin D more effectively).[33]
- Dose: there are two approaches, depending on severity. One option is 5,000 units daily for 2–6 weeks, then 1,000–2,000 units daily. Another is one tablet of high-dose cholecalciferol (50,000 units) monthly, with or without a loading dose. Check levels after 3 months.[47] Refer to clinical guidelines.
- Treatment may need to be lifelong, at least through the winter months. As vitamin D supplements are not on the PBS, this can become expensive for refugee clients, particularly where a large family may need ongoing treatment. It is not uncommon for people to stop and start supplementation. In such cases, ensure that pregnant and breastfeeding women have supplementation, and screen infants for vitamin D deficiency.[48]

- Calcium intake needs to be 1,000 mg per day, as calcium and vitamin D together promote bone healing.[33] Therefore it is important to educate patients about increasing the amount of calcium containing foods in their diet.
- Calcitriol is rarely required in adults with vitamin D deficiency and is best reserved for physician use due to the risks of hypercalcaemia.[47]
- Cod liver oil capsules are not suitable for vitamin D replacement, as the dosage required would also provide excessive vitamin A and may lead to toxicity.

Paediatric guidelines for the assessment and management of nutritional deficiency have been developed by the Royal Children's Hospital in Melbourne: www.rch.org.au/immigranthealth/resources.cfm?doc_id=10782

Also see Section 5 > Nutritional issues (p.192).

Referral

Children with hypocalcaemia or rickets need urgent specialist assessment.

Specialist referral is recommended for severe vitamin D deficiency with significant high ALP and PTH, and/or renal impairment, and in children with severe deficiency; or where levels are not increasing despite adequate supplementation, seek specialist advice.

RESOURCES

- Victorian Department of Health factsheets on vitamin D are available on the Department of Health's website – http://docs.health.vic.gov.au/docs/doc/Low-vitamin-D-in-Victoria:-Key-health-messages-for-doctors-nurses-and-allied-health-%280ctober-2011%29.
- The Better Health Channel has prinatable client information on vitamin D: www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Vitamin_D?open.
- The Vitamin D Background Paper for Health Professionals produced by the Association for Services to Torture and Trauma Survivors (ASETTS) may also be of interest: www.asetts.org.au/nutrition.htm.

Other nutrient and mineral deficiencies

Information on prevalence, causes, management and referral for other vitamin/nutrient deficiencies is summarised in Table 4.2.

TABLE 4.2 Vitamin/nutrient deficiency[30, 47]

Vitamin/ Nutrient Deficiency	Prevalence	Dietary sources	Common causes of deficiency	Clinical picture	Management and referral
Vitamin A	Predominantly affects older infants, young children, and pregnant and lactating women. In Africa and SE Asia 44–50% preschool children have VAD.	Liver, fish, butter, cheese, whole milk, egg yolk, green leafy vegetables, orange/ yellow-coloured fruits and vegetables (e.g. carrot, pumpkin, sweet potato, apricot, peach, pawpaw, mango, red capsicum).	Especially in children: insufficient quantities of vitamin A in breast and cow's milk. Poor access to vitamin A fortified foods or supplementation.	Hyperkeratotic skin lesions (goose bump rash), dry eyes, corneal ulceration and scarring; night blindness, blindness; increased susceptibility to infectious diseases; anaemia, poor growth and increased mortality	Screen children or treat empirically as per WHO guidelines. See Section 5.
B vitamins					
Thiamine B1	Endemic in areas with largely rice-based diets.	Pork, beef, legumes, nuts yeast extract, (Vegemite), wheat germ, wheat bran, nuts, liver, kidney, peas, wholemeal flour, sesame seeds.	Inadequate diets especially when milled rice is the main staple, consumption of foods containing thiaminases or antithiamine compounds, and prolonged cooking of foods. Alcoholism and HIV infection. Increased requirements are during pregnancy and lactation.	Anorexia; irritability; beri-beri with cardiovascular symptoms and/or symmetric peripheral neuropathy.	Dietary advice. Treatment with oral or parenteral thiamine is very effective.

TABLE 4.2 **Vitamin/nutrient deficiency** continued

Vitamin/ Nutrient Deficiency	Prevalence	Dietary sources	Common causes of deficiency	Clinical picture	Management and referral
Riboflavin B2	Corn-based diets in China, Africa, India	Milk, cheese, eggs, pulses, green vegetables		Angular stomatitis, cheilitis (also B3 deficiency)	
Niacin B3		Beans, milk, meat, eggs		Pellagra: anorexia, weakness, irritability, hyperpigmented skin and mucosal changes, diarrhoea, dementia	
Pyridoxine B6		All food groups, especially legumes, nuts, wheat, meat	Isoniazid	Epithelial changes, peripheral neuropathy; depression, confusion; microcytic hypochromic anaemia; platelet dysfunction	
B12 Folate See Table 4.3 > Types of Anaemia (p.119).					
Calcium	Common in those with vitamin D deficiency	Dairy, tinned fish, spinach, dry nuts	Lack of dietary intake	Muscle pain, brittle nails, fractures	Dietary advice. Screening for vitamin D levels
Vitamin D	Very common. Screen all new arrivals.	Few dietary sources. Sunlight (UVB)	Dark skin, little exposure to sunlight due to dress, housebound, those whose work hours inhibit sun exposure	See p.112	See pp.112-113

TABLE 4.2 Vitamin/nutrient deficiency continued

Vitamin/ Nutrient Deficiency	Prevalence	Dietary sources	Common causes of deficiency	Clinical picture	Management and referral
Vitamin C		Citrus fruits, broccoli tomatoes, potatoes, berries, guava, mango, capsicum, pawpaw, parsley, pineapple, spinach and cabbage	Inadequate diet, malabsorption	Impaired absorption of non-haem. iron. Impaired collagen formation Impaired immune function Impaired wound healing Scurvy: bleeding into skin, gums, joints; impaired bone growth in children	
Other fat-soluble Vitamins: vitamins E and K		Vitamin E: wheat germ, vegetable oils, nuts, seeds, margarine, eggs, whole grains Vitamin K: leafy green vegetables, liver, eggs	Coeliac disease, inflammatory bowel disease, malabsorption syndromes	Vitamin K: bleeding disorders	
Mineral deficiencies					
Iron	2–3 billion people are iron deficient worldwide. Affects an estimated 42% of all women, 58% of pregnant women, and $^1/_3$ of all young children in developing countries	Red meat, chicken and other meats, dark green vegetables (e.g. spinach)	Inadequate absorbable iron in the diet Blood loss associated with menstruation, haemorrhage in pregnancy, infections (hookworm, schistosomiasis, H. pylori). Other causes of blood loss Increased iron requirements during pregnancy, breastfeeding, high-growth periods.	Iron deficiency anaemia a primary cause of cognitive deficit in infants and young children In adults, physical work capacity is reduced with even moderate anaemia	Dietary advice. Rule out underlying causes, and especially in those >50 yrs of age consider GIT malignancy. Iron supplementation – intermittent dosing may be sufficient. Treat intestinal helminth infections and H. Pylori.

TABLE 4.2 **Vitamin/nutrient deficiency** continued

Vitamin/ Nutrient Deficiency	Prevalence	Dietary sources	Common causes of deficiency	Clinical picture	Management and referral
Zinc		Meat, shellfish, nuts	Common in many chronic diseases, malabsorption syndromes, sickle cell anaemia	Stunted growth, reduced taste, reduced immunity; poor wound healing' 'flaky paint' rash lower limbs, hair loss	
Iodine	Approximately 40% of population deficient across Africa and SE Asia	Sea fish, seaweed	Insufficient food sources of iodine, including iodised salt. Increased utilisation in pregnancy.	Goitre, congenital hypothyroidism. The single most important cause of preventable brain damage and mental retardation in children. Deficiency leads to poor cognitive development in children, and in pregnancy increased risk of still birth and miscarriage.	Screening not routinely practised in Australia. Suggest use of iodised table salt, iodine-fortified food, including bread.

Common blood disorders

Anaemia

Prevalence: 19–31% in newly arrived African refugees, with similar prevalence rates in some arrivals from the Middle East and Asia.[46, 49]

Different causes of anaemia may coexist. Contributors include iron deficiency,[50] malaria and parasite infection/infestation.

Clinical features

Clinical features include:

- Fatigue, lethargy, dizziness or faintness
- Headache, poor concentration
- Shortness of breath, palpitations, angina of effort, intermittent claudication (limp)
- Pallor, tachycardia, flow murmur, peripheral oedema, cardiac failure.[51]

TABLE 4.3 Types of Anaemia – clinical picture, investigations and management [51, 52, 53]

Type	Causes in the refugee population	Clinical picture	Investigations	Management and referral
Microcytic (Mean cell volume <80 fL)	Iron deficiency Haemoglobinopathy Sideroblastic anaemia Occasionally – anaemia of chronic disease			
Iron deficiency anaemia 50	Dietary insufficiency Infectious diseases: intestinal parasitic infection, schistosomiasis In women: menstruation, pregnancy In children: See Section 5 (p.198). Blood loss (especially gastrointestinal blood loss due to peptic ulcer disease, gastritis, colonic polyps, inflammatory bowel disease, and gastrointestinal malignancy) Malabsorption (due to coeliac disease, tropical sprue)	See Anaemia (p.118). Other features of iron deficiency include angular stomatitis, glossitis, brittle nails and koilonychias.	Investigations show low serum ferritin (definitions vary in different laboratories). Ferritin<15ng/mL (adults and adolescents). Ferritin<12ng/mL (children under 5 years). Ferritin<30–50ng/mL (with coexisting inflammation) Exclude hookworm and schistosomiasis infection. Take a detailed dietary history including intake of meat, inhibitors of iron absorption such as cereals, calcium and tea. Rule out GI malignancy in post-menopausal women and adult men.	Treatment: Oral iron (using commercial preparations containing at least 30–60 mg elemental iron per dose) See Table 5.7 (p.200) For severe anaemia Hb <8, seek specialist advice. Parenteral iron should be considered, on specialist advice, if patients are intolerant/refractory to oral iron, or blood losses exceed capacity to reabsorb iron. Secondary prevention: Dietician advice on iron-rich diet (especially meat); in vegetarians, recommend consumption of legumes, vegetables, nuts, with minimisation of concomitant consumption of unfortified cereals, tannins and calcium.
Macrocytic (MCV > 98 fL)	B12 deficiency Folate deficiency Drugs (e.g. zidovudine) Haemolytic anaemia Other haematological disease			

TABLE 4.3 Types of Anaemia – clinical picture, investigations and management continued

Type	Causes in the refugee population	Clinical picture	Investigations	Management and referral
Vitamin B12 deficiency	Pernicious anaemia Inadequate dietary intake (especially in vegans, or those consuming a vegan diet) Breastfeeding infants of B12 deficient mothers Malabsorption due to reduced gastric function, atrophic gastritis, gastrectomy, and small bowel bacterial overgrowth HIV infection	Megaloblastic anaemia Peripheral neuropathy, weakness, ataxia; spinal cord damage, optic atrophy, irritability, forgetfulness, dementia Beefy red tongue; anorexia, jaundice, weight loss	Serum B12 Anti-intrinsic factor Ab Anti parietal cell Ab	Parenteral treatment is essential for proven deficiency. See vitamin B12 deficiency Therapeutic Guidelines Australian Medicines Handbook Oral B12 replacement is not widely available. Dietary sources: fortified soy milk, and Animal foods such as offal (liver, kidney), lean meat, oysters, fish, seafood, eggs
Folate deficiency	Malabsorption (especially coeliac disease, tropical sprue) Low folate diet (low dietary diversity, low greens, meat intake) Alcoholism Excess goat's milk consumption	Megaloblastic anaemia Increased risk of neural tube defects (spina bifida and anencephaly) if deficient during pregnancy Anaemia, gastrointestinal symptoms; no neurological features	Serum and red cell folate Investigation of underlying conditions	Dietary sources: Green leafy vegetables, folate-fortified cereals and offal such as liver. It is particularly susceptible to destruction during cooking. Pre-conception: Eat a folate-rich diet and take folic acid 500 mcg orally, daily from at least 1 month prior to conception and in the first 3 months of pregnancy. If folate deficiency is diagnosed, exclude concomitant B12 deficiency and commence folic acid 500 mcg daily.
Normochromic normocytic (MCV 80–98 fL)	Early iron deficiency, chronic disease/inflammation, renal failure, infection (e.g. malaria, chronic sepsis)			

Haemoglobinopathies

Prevalence

5% of the world's population are carriers of a haemoglobinopathy.[54]

Investigations

Screening for a haemoglobinopathy in a refugee client is recommended in the following situations:[55, 56]

- abnormal red cell indices (not routine in children, for children see Section 5)
- prior to pregnancy (consider screening both partners): all couples where at least one partner is from Africa, Asia, the Middle East, the Pacific or the Mediterranean should be screened.
- a family member with a haemoglobinopathy.

The following investigations are recommended:

- full blood examination (insufficient alone as a screening test)
- iron studies (iron deficiency may mask Beta-thalassaemia trait so perform HB electrophoresis when iron replete)
- Hb electrophoresis +/– DNA studies for haemoglobinopathy

Sickle cell trait is not detectable on FBE alone. Testing for thalassaemia and haemoglobin variants requires FBE, iron studies and haemoglobin electrophoresis. If these results are suggestive of alpha thalassaemia, DNA analysis is required.

Partner screening is necessary in all cases where an abnormality is identified, and should also be performed in all clients who are pregnant and iron deficient with microcytic anaemia, as DNA studies may be required to determine thalassaemia risk if the partner demonstrates an abnormality.

Pregnant women in whom beta- thalassaemia minor is identified should receive high-dose folic acid (5 mg daily) throughout pregnancy, as there is some evidence that this is beneficial in optimising haemoglobin levels. Iron supplements should not be given in the absence of documented iron deficiency. Many clients with thalassaemia minor have a mild degree of iron overload, and iron supplements do not improve haemoglobin or red cell indices unless iron deficiency is present.[56]

Failing to detect that a couple has a significant risk of having a child with a haemoglobinopathy is an important medico-legal incident.

Inherited red cell disorders

TABLE 4.4 Inherited red cell disorders[30, 51, 53, 54, 55, 56, 57]

Type	Prevalence	Clinical picture	Management and referral
Red Cell Enzyme disorders Glucose 6 phosphate dehydrogenase deficiency (G6PD-deficiency)	Common in African, Middle Eastern and Mediterranean populations. Usually (but not exclusively) seen in males. Haemolysis precipitate by fava beans (usually Mediterranean type), medications (including antimalarials) and other stimuli.	Haemolytic anaemia (anaemia, elevated LDH, reticulocytes and bilirubin, reduced haptoglobin, bite cells/blister cells on blood film).	Test for G6PD (may be falsely normal during acute crises). Haemolysis screen. Remove precipitant. Refer to haematologist. May need transfusion acutely.
Red Cell Membrane disorders Hereditary spherocytosis Hereditary elliptocytosis		Diagnosis from blood film. May have splenomegaly.	Consider haemolysis screen (LDH, haptoglobin, reticulocytes, bilirubin). Consider flow cytometric diagnosis (E5M). Referral to haematologist. Commence Folate, 5 mg thrice weekly.
β-thalassaemia trait (heterozygosity)		Low MCV/MCH +/– anaemia Detectable by HbEPG (elevated HbA2% in many cases)	If both partners affected, urgent referral for genetic counselling is required to discuss risk of major thalassaemia syndrome. β-thalassaemia detected, screen for A thalassaemia as well, as may coexist.

TABLE 4.4 Inherited red cell disorders continued

Type	Prevalence	Clinical picture	Management and referral
β-thalassaemia major or intermedia (homozygosity)		Moderate or marked anaemia. Haemolysis, jaundice Skeletal and facial bone abnormalities (frontal bossing). Hepatomegaly Splenomegaly Iron overload Endocrine failure (osteoporosis, diabetes, growth failure, hypothyroidism).	Urgent referral to haematologist/ thalassaemia centre.
α thalassaemia trait (heterozygosity) α+ single gene deletion (α-/αα) αα two gene deletion (αα/--)		MCV/MCH low +/– anaemia Requires DNA studies.	Risk of HbH disease if risk of (α-/--) if risk of α+ and α0 coinheritenance. Risk of Bart's Hydrops Foetalis (--/--) if risk of α0 homozygosity At risk couples should be referred for genetic counselling.
α thalassaemia homozygosity		HbH disease (α-/αα) Mild, moderate or severe anaemia, may require periodic or regular transfusions. Splenomegaly. Bart's Hydrops Foetalis (--/--) foetal anaemia, hydrops and death in utero. Severe risk of maternal morbidity including pre-eclampsia.	Referral to haematologist or thalassaemia centre. Antenatal diagnosis is required.
Sickle cell disease Hb S homozygosity, or HbS compound heterozygosity with C, D, E, O or any other beta chain disorder (including β-thalassaemia trait).	5% of under 5 deaths on African continent, and 10–15% in West Africa	May present with anaemia, haemolysis, splenic enlargement, hyposplenism, sepsis, acute pain in limbs, back or chest, stroke, respiratory failure (mimicking pneumonia), organ failure.	Screen with Hb electrophoresis, sickling test. Urgent referral to haematologist or specialist centre.

TABLE 4.4 Inherited red cell disorders continued

Type	Prevalence	Clinical picture	Management and referral
Sickle cell trait	HbAS – 10–40% equatorial Africa, about 1% in north and South Africa.	Asymptomatic, normal red cell indices and haemoglobin. May experience sickling during extreme exercise, dehydration or altitude.	Refer to specialist If one partner has sickle cell trait, and the other has Hb S, C, D, E, O or any other beta chain disorder (including beta-thalassaemia trait) the couple is at risk of having a child with sickle cell disease. The couple must be referred for genetic counselling.
Other haemoglobin variants eg Hb E, C, D, O and Lepore	HbE – over 50% carriers in some areas (including Thailand, Laos, Cambodia, Sri Lanka, Burma and Vietnam). HbC – common in West Africa.	Asymptomatic, may be associated with a mild anaemia and microcytosis. Testing includes HbEPG and Hb gene studies.	Combinations with either HbS or ß thal trait may cause severe disease in children and couples at risk must be referred for genetic counselling. Homozygote HbCC may cause a mild haemolytic anaemia.

Sickle cell crises

May be regular or intermittent; even those with rare crises may develop chronic bone problems, pulmonary hypertension, stroke or pain.[50, 52, 58]

Precipitants of sickling[53]

- Hypoxia
- Dehydration
- Pain
- Fever
- Infection
- Pregnancy

Clinical features of sickling[53, 55]

- **Pain:** acute due to sickling crisis, or chronic due to avascular necrosis, bone infarction, splenic sequestration.
- **Chest syndrome:** a potentially life-threatening syndrome of progressive pulmonary infiltrates, with increasing hypoxaemia and increased sickling.
- **Stroke**: hemiparesis, dysphasia
- **Anaemia:** splenic sequestration: particularly in children: rapidly progressive anaemia with acute splenomegaly. Haemolytic anaemia, folate deficiency, aplastic crises (due to parvovirus B19).
- **Infections:** people with a sickle cell disorder are usually functionally asplenic and are particularly prone to serious and life-threatening infections including septicaemia, pneumococcal meningitis and osteomyelitis.
- **Other:** leg ulcers, bone pain, renal papillary necrosis, subarachnoid haemorrhage, retinopathy.

All patients with sickle cell disease should be referred to a specialist centre.

Patients suspected of having an acute crisis should be referred directly to an emergency department.

Eosinophilia

Eosinophilia is common in newly arrived refugees[58] and usually indicates parasitic infection, but also occurs in association with allergy.

Clinical picture

Eosinophilia reported on FBC:

- May indicate helminth infestation so test for strongyloides, schistosomiasis and intestinal parasites. See Infectious Disease and Parasites (p.127). Also consider testing for filariasis.
- Take a history for hay fever, asthma, and eczema.
- Take a detailed medication history.
- Exclude HIV and other blood-borne viruses.
- Persistent, marked eosinophilia may cause organ damage (especially cardiomyopathy) and should always be addressed.
- If still unexplained and persistent, refer to a haematology or infectious diseases clinic.

Benign ethnic neutropaenia[52, 59]

Prevalence

- Occurs in 25–50% of people with African ethnicities, and some Middle Eastern people
- Most common form of neutropaenia in the world
- Reflects a different normal range of neutrophils in these populations.

Clinical picture and management

- The client is clinically well, but has persistent low neutrophil and leukocyte counts.
- Be aware that a persistent low white cell count may be found on a routine health assessment.
- Exclude other causes (e.g. intercurrent viral illness, other infections or malnutrition) – again these conditions will usually be obvious if the client has had a health assessment.
- If the client requires regular review for other conditions (e.g. schistosomiasis serology or iron deficiency), it is useful to check the FBE at the same time.

Referral

- A persistent neutropaenia <2.0 x 109/L warrants discussion with a haematologist.
- Clients with a history of significant, recurrent oral, skin or genital bacterial infections may have genuine symptomatic neutropaenia.
- Clients should be instructed to present to a hospital if they develop a fever for urgent clinical assessment, FBE and antibiotics.

Infectious and parasitic diseases

Pre-departure screenings (visa medical screening and departure health check)

Infectious diseases are common in many of the countries from which refugee clients originate. Humanitarian Program entrants and asylum seekers may have undergone visa medical or a departure health check (DHC) screening for some communicable diseases. However, screening is not available everywhere and is voluntary and therefore coverage is not universal. There is also the possibility that an entrant may have acquired a disease subsequent to screening, or that a disease was missed in the screening process. See Section 6 (p.228) for more information on these screening processes.

A comprehensive refugee health assessment is recommended in all recently arrived refugees as well as in those who have been inadequately screened or lost to follow-up, even years after arrival. See Section 6 (p.228). Refugees who have travelled home to visit friends and relatives may also need re-screening. Immigrants from refugee-like backgrounds may suffer a similar burden of infectious disease as refugees and screening should be considered for full screening. In some cases those who have returned from long visits to family and friends in country of origin may require re-screening for some infectious or parasitic diseases.

It is very important that consent of the client is obtained prior to screening, and that the highest standards of confidentiality are maintained. The testing process, as well as the consequences of a positive result, should be discussed where relevant (e.g. HIV, tuberculosis, and hepatitis B and C).

Management of clients with known or suspected infectious or parasitic disease

Significant social stigma is associated with some infectious diseases, and a positive diagnosis should be given with sensitivity. Often people of refugee background appreciate a detailed and repeated explanation of diagnosis, investigations and treatment (see Section 7, p.257). Translated health information is invaluable for literate patients, and some websites that provide multilingual printable patient information are listed in Section 10 (p.316).

Generally, management will depend on a number of factors, including:

- the client's health (e.g. a recent arrival who presents with an acute illness of uncertain aetiology should be referred to a hospital with an infectious diseases service for diagnosis and management as soon as possible). See Section 11 (p.323) for local referral pathways in your state or territory.
- the seriousness of the disease and the extent to which diagnosis and management requires specialist expertise and the facilities of a hospital inpatient or outpatient service.
- whether the diagnosis is straightforward and easily treated. Clients in whom there are diagnostic dilemmas and/or multiple complex problems should be referred to a hospital infectious diseases unit or an infectious diseases specialist.

PRACTICE TIP

It is wise to contact the infectious diseases registrar on call at the hospital before referring the client in order to avoid delays in the Emergency Department. Referral to hospital is particularly indicated for clients with potentially serious infectious diseases, such as known or suspected malaria, meningitis, tuberculosis, leprosy, onchocerciasis, cysticercosis or leishmaniasis.

Malaria

Prevalence

In 2010 there were an estimated 216 million cases of malaria, 91% of which were caused by Plasmodium falciparum. Some 81% of these cases were in the African region, 13% in South-East Asia and 5% in north Africa and the Middle East.[60] Specific countries with a significant burden of malaria include those in southern, eastern, central and western Africa, as well as Burma, Cambodia, Indonesia, India, Laos, Malaysia, Nepal, Pakistan, Papua New Guinea, Timor-Leste, Thailand, Turkey and Vietnam. Malaria is also found in Afghanistan, Iraq, Iran and Syria.

Although Australia is malaria-free, a study of the prevalence of malaria among newly arrived refugees to Australia found a prevalence rate of 5- 8% in those from Sub-Saharan Africa[61, 62] and 21% in people from Central Africa. [46] A small study of disease prevalence in newly arrived refugees to Australia of Burmese background found a prevalence of less than 1%.[2]

Aetiology and transmission

Malaria is caused by protozoan parasites of the genus Plasmodium. The most common species are Plasmodium falciparum and P. vivax. The other species are P. ovale, P. malariae and P. knowlesi. P. falciparum is the most dangerous, as life-threatening complications may develop suddenly. Mixed infections are common. Malaria parasites are transmitted via the bite of an infected female anopheles mosquito.

Patterns of illness

The incubation period to parasitaemia may be 6–16 days, but symptoms may be delayed for weeks or months.[63] Acute symptoms of malaria include fevers, chills and muscle aches.

Severe complications such as cerebral malaria, pulmonary oedema, metabolic, renal and haematological disturbances, shock and death are most often caused by P. falciparum malaria, although P. vivax may occasionally cause complicated malaria. Children, pregnant women, non-immune individuals, and immunocompromised individuals (especially with asplenia) are particularly vulnerable to more severe infections.

Those from endemic areas may have partial immunity and therefore develop subacute or chronic infection that is asymptomatic or causes minor symptoms. Chronic infection may present with fevers, anaemia, headaches, nausea, mild abdominal pain, diarrhoea, failure to thrive, splenomegaly or thrombocytopaenia.

Investigations

Malaria should be excluded in all recent immigrants from malaria-endemic countries with fever or other suspicious symptoms. A symptomatic client requires 3 thick and thin blood films over 48 hours, preferably performed by an experienced laboratory. Laboratories may also perform a rapid antigen detection test (such as the ICT Malaria). For asymptomatic patients, screen with one thick and thin film and a rapid antigen detection test (such as the ICT Malaria Pf) for P. falciparum.

All new immigrants from or transiting through malaria-endemic countries should be screened for malaria, even if they have undergone treatment before arrival in Australia as part of their visa medical check.[64] For information on the visa medical check see Section 6 (p.228).

PRACTICE TIP

Most malaria does not follow the classic pattern of periodic fever with paroxysm of cold, hot and sweating stages. There should be a high index of suspicion for anyone from an endemic area presenting with fever, vomiting, diarrhoea, headache and muscle pain, even if they have been tested or treated for malaria.[65]

Management

Malaria treatment should be undertaken promptly with specialist infectious disease advice. Clients with P. falciparum are usually admitted to hospital to ensure that treatment is tolerated and parasitaemia cleared.

Treatment recommendations are available from ASID: www.asid.net.au/downloads/RefugeeGuidelines.pdf.

Malaria is a notifiable disease.

Tuberculosis (TB)

Sensitivity around diagnosis, treatment and prognosis of TB is important, as severe stigma and discrimination surrounds this disease in some cultures. Patient information resources are helpful. See Section 10 (p.318).

Prevalence

The WHO estimates that 2 billion people worldwide have TB infection, leading to 3 million deaths annually. Of those with latent TB (LTBI), about 10% (5% in the first 2 years after infection and then 0.1% per year if immunocompetent) will go on to develop active TB later in life. Australian data suggests that few refugee adults arrive in Australia with active TB. The prevalence of LTBI is more common, and the prevalence of a positive tuberculin skin test (TST) has been reported in 25–55% of arrivals from Africa, Europe and the Middle East.[40, 41, 62]

Transmission

TB is mainly transmitted via airborne particles from individuals with active pulmonary TB. Latent TB and most other forms of active extra-pulmonary TB are not infectious (exceptions include renal and laryngeal infection).[63]

Patterns of infection and illness

TB infection may be primary, active or latent, and is most commonly caused by Mycobacterium tuberculosis. Primary (initial) infection usually goes unnoticed, with the majority of lesions healing. The infection may progress to active clinical disease in the form of pulmonary or extra-pulmonary TB, or become inactive. Inactive infection is referred to as latent TB infection (LTBI) and is not infectious to others. Of those with LTBI, about 10% (5% in the first 2 years after infection and then 0.1% per year if immunocompetent) will go on to develop active TB later in life.

Active TB

The risk of active TB is lifelong, but is greatest in the first 2 years following primary infection and in the first 5 years after migration. Active TB presenting as pulmonary, nodal, bone and disseminated TB may also develop through reactivation of LTBI after some years. It is important to think of active TB in any client with any chronic unresolved symptoms, including cough, bone pain, weight loss, abdominal pain, malaise, fevers or night sweats, especially if they originate from a high-prevalence area. Children under five are at increased risk of developing serious forms of TB such as miliary and meningeal TB. See Section 5 > Tuberculosis screening (p.201).

Diagnosis of active TB

In suspect active TB cases (e.g. persistent fever or cough), consult an infectious diseases physician. Diagnosis is based on clinical symptoms/signs, radiography, acid-fast bacilli smear and culture from sputum or other clinical specimens.[63] In some laboratories, a PCR may also be performed on these specimens. The Mantoux test and interferon gamma assay (IGRA, such as QuantiFERON® –TB Gold) are often negative in active TB.

Management of active TB

If a positive diagnosis of active TB is made, management is usually provided by infectious disease specialists, who can be contacted through the health department in each state and territory. Active TB is a notifiable disease with state or territory health authorities being responsible for arranging and conducting contact tracing upon receipt of a notification. Screening of close contacts of those with active and past TB infection is important.

Contact your state or territory health authority for details and information about surveillance and tracing, clinical matters and the availability of printed material for people of refugee background clients.

Guidelines Management, Prevention and Control of Tuberculosis: Guidelines for Healthcare Providers 2002–2005 as well as other state and territory guidelines are available to download from the Victorian Government Health Information website: www.health.vic.gov.au.

Latent TB (LTBI)

Latent TB describes the condition of being infected with TB without evidence of active disease. Patients should be informed that it is not infectious.

It is important to screen for latent TB in all new arrivals, with the exception of those with past documented infection.

HISTORY

Ask the patient if they:

- have had TB in the past and, if so, the type and duration of treatment
- are currently symptomatic (e.g. chronic cough, fevers, night sweats, lymphadenopathy, malaise, anorexia, weight loss, failure to thrive in children)
- are on a Health Undertaking or currently receiving treatment for TB. See Section 6 > Health Undertaking (p.230).
- have been exposed to TB from an infectious contact.

INVESTIGATIONS

Visa medical screening of refugees and special humanitarian entrants for active TB includes a chest X-ray (CXR) for those 11 years or older and clinical examination. This may be undertaken 6–9 months prior to departure. A departure health check may also be undertaken 72 hours prior to departure for Australia and may include an evaluation of previous known cases of TB.

Screening for latent TB is recommended in all refugees, preferably within 2 months of arrival in Australia.[64] Either a Mantoux test or IGRA, (such as QuantiFERON® –TB Gold) is suitable for screening adults. However, in children less than 13 years of age IGRA has not been validated. While TB screening has been found to be highly acceptable in some refugee groups,[66] it requires before and after test counselling due to stigma about the infection in some cultures.

Mantoux tests should only be given by an accredited provider. A Mantoux test is considered positive if it is ≥10mm in adults and children 5 years or older, and ≥5 mm in children <5 years or in those with HIV infection. IGRAs do not attract a Medicare rebate at present, unless it is stated that the client is immunocompromised.

Only clients with clinical symptoms, or a positive Mantoux test or IGRA, require a CXR.

MANAGEMENT OF LATENT TB

Anti-tuberculosis chemoprophylaxis (usually with isoniazid monotherapy) decreases the risk of reactivation of LTBI. Clients with positive screening tests should have further review by the local infectious diseases service for consideration of chemoprophylaxis. Chemoprophylaxis with isoniazid is usually given for 9 months and compliance must be high to be effective, and to prevent mycobacterial resistance developing. Many patients may have had an inadequate diet for a prolonged period before migration and so it is reasonable to give pyridoxine (vitamin B6) with isoniazid to reduce the risk of isoniazid-induced peripheral neuropathy (which often presents with clients complaining of ‘burning feet’). Even if not offered chemoprophylaxis because of age (there is increased hepatotoxicity associated with isoniazid use in older clients) or because of potential non-compliance, patients will usually be followed for 2 years with 6-monthly CXRs to exclude TB reactivation.

KEY POINT

TB SCREENING IN ADULTS

- Screen all newly arrivals for latent TB infection, with the exception of those with past documented infection
- Take detailed history to determine:
  - If the person had TB in the past and if so, the type and duration of treatment
  - If the person currently symptomatic
  - Whether there are any medical records of TB from overseas/onshore medical screenings
  - Whether the person has a Health Undertaking (see Section 6, p.230) or is currently receiving treatment for TB
  - If the person been exposed to TB from an infectious contact
- If there is no documented past infection perform either a Mantoux test or IGRA (such as QuantiFERON® –TB Gold) for adults. This is not suitable for those under 13 years, see Section 5 (p.201) for child screening.
- IGRAs do not attract a Medicare rebate at present, unless it is stated that the client is immunocompromised.
- While TB screening requires a sensitive approach, including before and after test counselling. Be aware that there is significant stigma about the infection in some cultures.
- Contact your state or territory health authority for details and information about surveillance and tracing, clinical matters and the availability of printed material for clients.
- Sensitivity around diagnosis, treatment and prognosis of TB is important, as severe stigma and discrimination surrounds this disease in some cultures.
- Active TB is a notifiable disease.

Viral hepatitis

Several forms of viral hepatitis may be diagnosed in newly arrived refugees in Australia. Along with the traditional trio of hepatitis A, B and C also consider hepatitis D (transmitted by bodily fluids) and E (transmitted by the faecal–oral route). Hepatitis D requires hepatitis B as a natural helper virus, and so may occur at the time of hepatitis B infection or later in a chronic carrier. It may present as a moderate to severe illness with a high mortality, and a significant risk of chronic liver disease. Hepatitis E may be asymptomatic. It has a high mortality rate if acquired during pregnancy.

Causes of jaundice, other than viral hepatitis, in the refugee population may include malaria, leptospirosis, EBV, CMV, haemolysis, drug and alcohol-induced hepatitis, metabolic disorders, and gall bladder disease.[51]

Clinical picture

The clinical features of acute viral hepatitis include a prodromal phase of anorexia, nausea and vomiting, malaise, fever, headache and possible diarrhoea and upper abdominal pain (25% have small joint polyarthritis); and an icteric phase of dark urine, pale stools, hepatomegaly (10% have splenomegaly). Not all clients develop jaundice. Some will have transient rashes. The acute illness is usually of 3–6 weeks duration.[51]

Initial investigations[31]

If acute viral hepatitis is diagnosed in a refugee client, consult with an ID physician. The following investigations are essential:

- LFTs Clotting profile/INR
- serology for Hep B sAg, sAb, cAb (IgM and IgG), eAg
- serology for hepatitis C
- serology for hepatitis A
- other tests depending on the clinical picture.

General principles of management[31, 51]

- Avoid sedatives and NSAIDs; cease OCP until recovery.
- Cease alcohol and other hepatotoxic drugs.
- Inform patients about disease process and infectious risk.

All forms of infectious hepatitis are notifiable diseases.

Hepatitis B

Prevalence

The hepatitis B carrier rate is significantly higher in some refugee populations than the rate in people born in Australia. Tiong et al. demonstrated a hepatitis B carriage rate of 8% in 258 newly arrived African refugees.[46] The Migrant Health Unit in Western Australia found a carrier rate of 5% among 2011 refugees in 2003–04.[62]

Screening

The Australasian Society for Infectious Diseases (ASID) recommends screening all newly arrived refugees as well as those who have resided in Australia for longer periods and who have not been screened.[64] Only certain categories of applicants are tested before arrival in Australia.[67] For the individual, diagnosis of chronic hepatitis B is important because management includes assessment for treatment with antiviral agents and monitoring for progressive liver disease and hepatocellular carcinoma.

Transmission

The most common forms of transmission in people of refugee background residing in Australia are:

- perinatal and infancy – in endemic areas most transmission occurs from mother to child at the time of birth or in the first few months of life
- close prolonged family or household contact
- exposure to infected bodily fluids, especially blood or via sexual transmission.

Patterns of illness and clinical picture[51]

If infected with hepatitis B:

- perinatally, as is the case for most immigrants and refugees from developing countries, only about 5–25% of infants clear the virus depending on the e Ag status of the mother. The rest become chronic carriers and are at risk of the complications of chronic hepatitis B (chronic active hepatitis, cirrhosis and/or hepatocellular carcinoma).
- in adulthood, 95% of individuals clear the virus and become Hep sAg negative, and Hep B cAb and sAb positive. Adults may develop acute hepatitis, which may be severe, but less than 1% will develop fulminant hepatic failure.

- 5% will become carriers – most healthy, but 20–25% may develop the complications of chronic active hepatitis, cirrhosis and/or hepatocellular carcinoma. For more information see Chronic Disease (p.159).
- some refugees are found to be positive for core antibody yet s Ab negative, and are called 'silent carriers'. These individuals may need specialist advice for interpretation as they require a HB virus PCR to exclude viraemia. If positive they should be managed as for other chronic carriers.

Management and referral[31]

- Hepatitis B carriers and clients with chronic hepatitis B should be counselled regarding the precautions required to prevent transmission (i.e. not sharing domestic items capable of causing skin penetration such as combs, nail brushes, toothbrushes and razors).
- All non-immune household contacts should be vaccinated.
- All newly diagnosed patients should be referred to an infectious diseases physician for development of a care plan that will include routine six monthly blood tests, abdominal ultrasound (if required), foeto protein testing (when required) and viral loading tests.
- Those with abnormal liver function tests and HepBeAg positive should be referred to a liver or infectious diseases specialist for follow-up, as they are at risk of developing complications and will be assessed for active treatment.
- Sensitivity around diagnosis, treatment and prognosis is important as stigma surrounds this disease in some cultures. Patient information resources are helpful. See Section 10.
- Immunisation: immunise hepatitis B carriers against hepatitis A.
- Vaccination of all non-immune refugees and immigrants is recommended as they have increased risk of exposure to HBV through their families, communities and through visits to their home country. A universal hepatitis B program for infants has now been implemented in Australia as part of the new standard immunisation schedule. Pre-adolescent hepatitis B vaccination is now recommended at 10–13 years.

Hepatitis B is a notifiable disease.

PRACTICE TIP

Newly arrived refugee families in the same household often have varying levels of immunity to hepatitis B. It is common to see carriers, immune and non-immune individuals all together, and hence the non-immune are at great risk. Thus vaccinate at-risk non-immune individuals as soon as possible if a family member is found to be a carrier.

RESOURCE

The Australasian Society for HIV Medicine (ASHM) and the Cancer Council of NSW have put together a downloadable resource designed to give primary care practitioners an overview of current hepatitis B knowledge in Australia. It is available from the ASHM website http://ashm.org.au/images/publications/monographs/b%20positive/b_positive-all_you_wanted_to_know.pdf>.

Hepatitis C

Prevalence

There is a range of prevalence rates of hepatitis C virus (HCV) between and within countries depending on risk factors.[68] In Egypt (a country of transit for many African refugees), a high prevalence of HCV infection has been found. In some rural villages, the prevalence of HCV is 40% among older adults, compared to 2.7% in young adults.[69] In Australia, though, hepatitis C has been detected uncommonly in refugees.[70]

Transmission

Hepatitis C is spread through sharing needles, exposure to blood products, and medical procedures using contaminated equipment. Sexual transmission is rare. Mother-to-child transmission can occur during pregnancy and childbirth, at rates of 4–7%. The risk of transmission is higher for mothers infected with HIV.[71, 72]

Many refugees have been potentially exposed to hepatitis C through medical and other procedures. Due to lack of epidemiological data in many developing countries, the actual risk of exposure is unknown.[73]

Patterns of illness and clinical picture

Hepatitis C is often asymptomatic, and 60–80% of people infected will develop chronic infection. Of those chronically infected, 20–30% progress to cirrhosis, and 0–3% develop hepatocellular carcinoma, the latter occurring almost exclusively in those with cirrhosis.[63, 74] The risk of disease progression is increased by alcohol use, older age at infection, male gender, and co-infection with HIV or hepatitis B.[74]

Initial investigations

All new arrivals should be offered screening for hepatitis C, using an EIA for anti-HCV virus antibody with pre-test counselling.[64] The aim of screening for hepatitis C is to identify individuals who may be infected and enable follow-up for treatment. The presence of anti-HCV antibodies establishes the presence of past or chronic infection. These antibodies are detectable 1–3 months after infection. Anti-HCV antibody testing is unreliable for acute infection, as up to 30% of acutely infected individuals will have undetectable antibodies at the onset of their symptoms.[75]

LFTs and confirmatory testing with PCR for HCV RNA should be ordered in those with positive HCV antibodies, indicating chronic infection. Further confirmatory tests may be performed if HCV RNA is negative. HCV RNA is also used to diagnose acute infection. Detection of HCV RNA indicates ongoing viral replication, active disease, and a higher risk for transmission. Undetectable HCV RNA in peripheral blood may indicate clearance of the infection (spontaneously or following treatment), but exposure to the blood of a person with anti-HCV antibodies should be followed up as a high-risk event for transmission, even if the source has undetectable levels of HCV RNA.[63]

Management and referral

All patients with positive hepatitis C serology should be given appropriate psychosocial support and informed adequately about disease monitoring and potential treatment (see the RACGP Hepatitis C Guidelines at the link listed under treatment on p.140). Patients should receive information about preventing transmission (by taking care with potentially blood contaminated products, e.g. razors, toothbrushes, needles). If LFTs abnormal or HCV RNA is positive referral to a specialist clinic (liver or infectious diseases) is recommended for further tests and assessment.

Treatment

Effective treatment for hepatitis C is available. Treatment can often prevent progressive liver damage and clear the infection. New combination therapies that may vastly improve outcomes are becoming available.[75]

See RACGP Hepatitis C Guidelines 2003 Update at www.racgp.org.au/guidelines/hepatitisc, and the guidelines from the American Association for the Study of Liver Diseases Practice Guidelines on Chronic HCV Infection here: www.aasld.org/practiceguidelines/Pages/default.aspx.

Immunisation

Currently there is no vaccine available to prevent transmission of hepatitis C.

All clients with hepatitis C virus who are serologically negative for hepatitis A and B should be vaccinated against these viruses.

Prevention

Hepatitis C infection is preventable by avoiding exposure to potentially infected blood products, although this is difficult in many developing countries. There is no effective vaccine, and immunoglobulin following exposure is not protective.

KEY POINT

The following are notifiable conditions to your state health authority:

- Hepatitis B
- Hepatitis C
- HIV
- TB
- Syphilis
- Gonorrhoea
- Chlamydia

HIV

Prevalence

The prevalence of HIV remains highest in many areas of Sub-Saharan Africa, and is increasing in South and South-East Asia, the Middle East and Central Europe.[76]

Prevalence of HIV infection among refugees on arrival in Australia is not suspected to be high. A recent Victorian study has shown the rate of HIV infection in a small study of 156 Burmese refugees to be 0.7%[2]. A Western Australian study found that of 2,111 refugee and humanitarian entrants accepted by Western Australia in 2003–04, only two people were HIV-positive. However, both had been recorded as being HIV-negative in pre-departure screenings (see Section 6 > Visa medical and departure health check, p.228).[62]

Before resettling in Australia, applicants for permanent visas undergo testing for HIV (for those 15 years and older), have a chest radiograph to exclude active tuberculosis (TB) (for those 11 years and older), and may undergo other testing, depending on exposure risk. There is sometimes risk of exposure to HIV during the interval between the pre-migration test and the time of migration.[77]

Screening and referral

All refugees should be offered confidential HIV screening and given information about the transmission and prevention of HIV, as well as the availability of effective treatment, and good prognosis of HIV disease in Australia.[64] If blood-borne or sexual exposure has occurred in the 3 months prior to HIV testing, it should be repeated 1 and 3 months after the initial test. A person with recent potential exposure to HIV infection should be advised to practise safe sex and avoid placing others at risk of HIV transmission (sexual, blood-borne, or pregnancy-related) until the diagnosis has been excluded. Post exposure prophylaxis may be indicated (see below). If the HIV test is positive, the individual should be referred to an ID physician, and the diagnosis notified to the state or territory public health unit.

Transmission

HIV is contracted through exposure to blood, genital fluids or breast milk of an infected individual. The virus does not pass through intact skin, and is not transmitted via saliva. HIV does not spread through airborne or droplet routes.

Immunisation

Currently there is no vaccine available to prevent HIV infection.

Patterns of illness and clinical picture

After exposure to HIV, an infected individual may experience a 'seroconversion illness', resembling the glandular fever syndrome. Symptoms include fever, rash, lymphadenopathy, and often gastrointestinal disturbance. At this time, the HIV antibody test is negative or indeterminate. Diagnosis of acute HIV infection requires detection of viral proteins such as p24 antigen, or nucleic acids. Most HIV test assays used in Australia now detect both HIV viral antigens and antibodies to HIV, shortening the 'window period' between acquisition of HIV infection and detection of the infection by diagnostic tests.

The symptoms of acute HIV disease usually subside spontaneously, and the infected individual remains asymptomatic for several years before progressive immune dysfunction leads to the onset of opportunistic infections such as TB or pneumocystis jiroveci pneumonia (PCP or PJP).

The HIV antibody test becomes positive 6–12 weeks after infection,[78, 79] although combined antibody/antigen assays may become positive as early as the second week after HIV infection,[80] definitive diagnosis of HIV infection is made only after detection of HIV antibodies by western blot.

Prevention

HIV infection is preventable by avoiding exposure to potentially infected blood, genital fluids and breast milk. Mother-to-child transmission can be prevented using antiretroviral drugs and avoidance of breastfeeding. If sexual or blood-borne exposure occurs, the exposed individual should be offered post-exposure prophylaxis with antiretroviral drugs, which may decrease the risk of acquiring HIV if commenced within 72 hours. Antiretroviral therapy with suppression of viral replication also reduces (but does not eliminate) sexual transmission.[63, 79]

It is important to explain to sexually active clients that there is a risk of acquiring HIV during trips back to countries of origin or transit (often undertaken by those now well settled in Australia and keen to trace, visit and assist family still overseas). Even within the Australian context, safe sex should be practised.

Treatment

It is not possible to cure HIV infection using treatments that are currently available. However, treatment with antiretroviral drugs can prevent progression to AIDS, prolong survival and improve the quality of life, for people infected with HIV. Treatment of people living with HIV/AIDS can also reduce the likelihood of further sexual or mother-to-child transmission.[79]

Follow-up

Ongoing management of a client infected with HIV is best undertaken by a specialised infectious diseases unit, in close collaboration with the client's GP.

Stigma and social consequences

For many people arriving in Australia as refugees – as in the many Australian-born communities – HIV is still associated with fear, stigma and discrimination.[77, 81] Disclosure of HIV infection to other community members can lead to ostracism and social isolation. For this reason, discussion of the issue should be undertaken with due regard to privacy and confidentiality. The professional confidentiality of interpreters is critical in this situation.[77]

KEY POINTS

- Offer HIV screening, with appropriate counselling, to all newly arrived refugees, and to those returning from overseas.
- For screening purposes, especially for adolescents and older unaccompanied minors (who may be sexually active or have been exposed to sexual violence), it is not necessary to attempt a detailed sexual history prior to screening.
- The key point is to advise that an HIV test may be negative if 'at-risk' behaviour (unprotected intercourse, IV drug use, or injection/surgery/blood transfusion in a resource-poor country) has occurred in the 3 months prior to the test.
- Emphasise the good prognosis of appropriately treated HIV infection in Australia.

Parasites

General prevalence

Intestinal parasite infections are widespread in most developing countries, and are among the most prevalent illnesses in newly arrived refugees.[70, 82] A study involving 258 refugees attending GPs in Melbourne suburbs in 2005 found that 15% had pathogenic gastrointestinal parasite infections, and 12% and 9% had schistosoma and strongyloides antibodies detected respectively.[46] A recent study of 187 refugee patients who had attended a Darwin refugee primary health service in 2009–2010 found a prevalence rate of 17% for schistosomiasis.[2] A survey of Burmese refugees visiting an Australian teaching hospital in 2009 found that 26% tested positively for strongyloidiasis.[2]

Schistosomiasis

Prevalence and transmission

Schistosomiasis affects 200 million people worldwide, 85% of whom live in Africa. It has recently been estimated that there are 130,000 deaths in Africa each year due to portal hypertension from intestinal schistosomiasis, and there are 70 million people with haematuria and 10 million with hydronephrosis due to urinary schistosomiasis.[83] Schistosoma is endemic in Africa (often known in South and East Africa as 'Bilharzia'), but is also found in Asia (including Burma) and the Middle East (especially Egypt). A Melbourne study of Burmese refugees in Australia found a prevalence rate of 5.4% screened positive for schistomiasis serology.[2]

Patterns of illness and clinical picture

- Schistosoma types in Africa include S. haematobium, S. mansoni and S. intercalatum, and in South-East Asia include S. japonicum and S. mekongi.
- Acute schistosomiasis (Katayama fever): this condition is rare in refugees but important to recognise, as it may be severe. Clinical features include eosinophilia, fever, arthralgia, headache, cough, abdominal pain, diarrhoea, hepatosplenomegaly, lymphadenopathy and urticaria. The central nervous system (CNS) and spinal cord may be involved.

- Chronic schistosomiasis is the most common type in immigrants and refugees who have lived in endemic areas and have higher parasite burdens. The onset is insidious and complications depend on the species of schistosome causing infection, the duration and severity of infestation, and the immune response to the eggs. Involvement of urinary, intestinal, hepatic, neurological and respiratory systems may occur. Neurological schistosomiasis is rare but important, as it may occur with a low parasite burden.
- It may be asymptomatic or mildly symptomatic; some patients develop significant long-term complications.

Complications

- Liver: noncirrhotic periportal fibrosis may lead to portal hypertension, hepatosplenomegaly, oesophageal varices and gastrointestinal haemorrhage. Hepatitis B and C co-infection may hasten progression of liver disease.
- Urinary tract schistosomiasis may be asymptomatic or may present with microscopic or macroscopic haematuria, dysuria, and urinary frequency. Fibrosis and calcification of the bladder may cause obstructive uropathy, leading to renal failure, or predispose to secondary bacterial infections with pyelonephritis. Carcinoma of the bladder (occurring usually 10–20 years after the initial infection) can occur. In addition, immune complexes that contain worm antigens may deposit in the glomeruli, leading to glomerulonephritis and nephrotic syndrome.
- Female genital schistosomiasis (FGS): S. haematobium may cause lesions in the female lower genital tract (i.e. cervix, vulva, vagina). FGS may facilitate the spread of some sexually transmitted diseases such as HIV and human papilloma virus (HPV).
- CNS: Most cases of cerebral schistosomiasis are observed with S. japonicum, constituting 2–4% of all S. japonicum infections. However, CNS schistosomiasis also can occur with other species. Spinal schistosomiasis usually presents as transverse myelitis and primarily is due to S. mansoni infection. It may occur early in infection, and in patients with a low parasite burden.

Initial investigations

- Schistosomiasis serology screening is recommended in all new arrived African or South-East Asian refugees. However, serology may remain positive for many years after treatment.
- If serology is positive, collect a urine and faecal sample for ova detection. This aids in species identification and later monitoring of response to therapy.
- Haematuria on mid-stream urine: present in 50–60% of people with urinary schistosomiasis and if persistent suggests the need for follow-up investigations.
- FBE may show eosinophilia.

Management and referral

- Praziquantel 40 mg/kg in two divided doses (20 mg/kg each), 4 hours apart, has been shown to have excellent cure rates in S. haematobium and S. mansoni infection acquired in most areas in Africa, and is generally safe and well tolerated.
- In refugees from South-East Asia where S. japonicum is prevalent, praziquantel 60 mg/kg in two (30 mg/kg) or three doses (20 mg/kg) 4 hours apart is recommended.[64]
- Mild side effects occur in 5–30% of clients, and include nausea, dizziness, headache, diarrhoea and pruritis.
- Treatment failure rates after praziquantel have been reported, and may be due to drug resistance or poor compliance. However, even if the infection is not cured, a single treatment will significantly decrease the worm burden and lessen the chance of complications developing.

Follow-up

After successful treatment, eggs continue to be excreted for up to 6 weeks, thus repeat stool or urine microscopy to document cure should be delayed for at least 8 weeks. Consultation with an infectious disease physician is recommended if positive stool or urine cultures or eosinophilia persist. Serology is not a useful test of cure, as it may remain positive for years. Refer to page 33 ASID guidelines for more information about follow-up.

KEY POINTS

- The prevalence of schistosomiasis in African immigrants is high, and the condition should be treated.
- Most infections are light and asymptomatic, but it is important to ask about symptoms that may suggest complications.
- Screen clients with serology and urinalysis for haematuria. If positive, collect urine and stools for microscopy for schistosoma ova. If complications are suspected arrange liver or bladder ultrasound and referral.
- Treat with praziquantel according to the ASID or Antibiotic Guidelines and monitor stool or urine microscopy (if positive) and eosinophil count.[64, 84]

Strongyloides stercoralis

Prevalence

Strongyloides stercoralis is an intestinal nematode that occurs widely in the tropics and subtropics and less commonly in temperate areas. The infection is more common in those living in rural areas, institutions and in lower socioeconomic groups. Recent Australian studies show prevalence rates in newly arrived refugees ranging from 5% to 26%.[1, 2]

Transmission

Transmission occurs by contact with soil or surface water containing filariform larvae. Larvae enter through intact skin and travel to the lungs, where they penetrate the alveolar spaces and are carried through the bronchial tree to the pharynx. They are then swallowed and reach the intestine, where they mature to adult worms, producing larvae that are excreted. In some clients, these larvae become infectious within the bowel and can reinvade enteric mucosa or perianal skin. This process is called 'autoinfection', and in this way the infection can sometimes be maintained for decades.

Patterns of illness and clinical picture

- Approximately 30% of infected individuals are asymptomatic, maintaining infection with a small number of worms by autoinfection.
- Pulmonary symptoms (Loeffler-like syndrome) and eosinophilia may occur as larvae penetrate alveolar spaces.
- Intestinal symptoms include intermittent watery diarrhoea, nausea, vomiting, abdominal pain and weight loss.
- Skin: A cutaneous linear eruption (larva currens), urticarial and other macular papular skin rashes in the buttocks and trunk areas also occur.
- Chronic strongyloidiasis may be complicated by life-threatening secondary gram-negative septicaemia/meningitis. Autoinfection may also lead to massive larval invasion of the lungs and intestines ('hyperinfection syndrome' or 'disseminated strongyloidiasis'), usually in immunocompromised patients (especially those receiving corticosteroid therapy).

Initial investigations

FBE will often show eosinophilia.

Strongyloides serology (EIA) detects IgG antibodies and is used for both screening, diagnosis and post-treatment monitoring.

Antibody levels decline slowly after successful treatment (over 1–2 years in most cases). There may be cross reactivity with sera from clients with other parasitic infections, especially filarial and nematode infections.

Faecal microscopy is insensitive, with more than five specimens required to achieve an 80% sensitivity.

Treatment

Ivermectin 200 mcg/kg/day given for two doses 2 weeks apart to ensure that larvae migrating through tissues at the time of the first dose are exposed to the drug with the second dose.[85] Two doses given on two consecutive days has also been shown to have high efficacy.[86, 87]

If from Central or West Africa consider the risk of loaisis (e.g. an infection caused by the parasitic worm Loa loa) before giving treatment. See the ASID Guidelines for alternative treatment.[64]

If the child weighs <15 kg, ivermectin is not recommended. Refer to a paediatrician. See Section 5 > Parasites (p.209).

Ivermectin is 94–100% effective after two doses.[87]

Follow-up

Follow-up with repeat eosinophil count and serology at 3–6 and 12 months.

If serology fails to decline, or declines and then rises, retreatment is warranted.

Hookworm (Ancylostoma duodenale, Necator americanus)

Prevalence and transmission

Hookworm infection is found mostly in poor and rural communities worldwide, especially where there is faecal contamination of soil and high humidity. Infection is most common in adults. Larvae penetrate through intact skin especially in areas where shoes are not worn (A. duodenale can also be transmitted via the oral route). Larvae migrate through the lungs developing into adult worms that live in the lumen of the small intestine. Here they feed from the small intestinal mucosa, causing chronic blood loss. Adult worms have a life span of several years.

Patterns of illness and clinical picture

Migration of larvae through the lungs may produce cough, wheeze, fever and eosinophilia within 1–2 weeks of infection. This phase is self-limiting, lasting 1–2 months. As worms attach to intestinal mucosa, epigastric pain, nausea, vomiting, diarrhoea and weight loss may occur. Iron deficiency anaemia is the major problem in moderate and severe infections, especially in women of reproductive age and children who have higher iron requirements.

Initial investigations

FBE may show eosinophilia.

Microscopic finding of eggs in faeces. Concentration methods are necessary to detect light infections.

Round worm (Ascaris lumbricoides)

Prevalence and transmission

There is a worldwide distribution of this nematode with an estimated 1.4 billion people infected, especially Asia, Africa and Latin America. The infection is most common in children in tropical and subtropical regions and areas with inadequate sanitation.

Patterns of illness and clinical picture

Infection is usually asymptomatic (an incidental finding in the stool, or a history of passing a worm), or there are mild gastrointestinal symptoms such as abdominal pain, distension, nausea, and occasional diarrhoea. Occasionally a worm is coughed up. Nutritional disorders may occur in children with a moderate to heavy worm burden. Pulmonary ascariasis (eosinophilic pneumonitis or Loeffler's syndrome) may occur 4–16 days after infection and presents as a self-limiting pneumonia (cough, dyspnoea, and haemoptysis) that usually resolves in a few weeks. Corticosteroids are useful in treating severe cases.

Initial investigations

- Finding of eggs on faecal microscopy
- Peripheral eosinophilia may be present (often >20% in pulmonary ascariasis)
- In pulmonary ascariasis, chest X-ray shows diffuse pulmonary infiltrates.

Whip worm (Trichuris trichiura)

Prevalence and transmission

The infection is most prevalent in children (5–15 years). Estimates suggest that 800 million individuals may be infected worldwide, especially in warm, moist areas with poor sanitation. Transmission of this nematode is by the ingestion of eggs from soil-contaminated hands or food. The eggs then hatch in the small intestine, and release larvae that mature and establish themselves as adults and attach in the appendix, caecum and ascending colon. The unembryonated eggs appear in faeces about 2 months after infection. The life span of adult worms is about 1 year. T. trichiura is often found together with A. lumbricoides.

Patterns of illness and clinical picture

Patients are usually asymptomatic or have mild abdominal discomfort. In heavily infected individuals there may be epigastric pain, vomiting, anorexia and weight loss. Some people develop dysentery with bloody diarrhoea, and rectal prolapse. In severe chronic cases, anaemia and growth retardation have been reported.

Initial investigations

- Microscopic identification of eggs in faecal specimens.

Hookworm, Roundworm, Whipworm Treatment

- Treat with Mebendazole or Albendazole
  - Mebendazole* >10 kg: 100 mg twice daily for 3 days orally ≤10 kg: 50 mg twice daily for 3 days orally

    or
  - Albendazole* >10 kg: 400 mg 1 dose orally ≤10 kg: 200 mg 1 dose orally

    *Note: NOT used in pregnancy or in children <6 months of age.

or

- Pyrantel embonate 20 mg/kg stat (max. 750 mg) orally. Repeat after 1 week if heavy infection
- Where appropriate, treat iron deficiency anaemia.

Follow-up

Repeat the faecal examination 2–4 weeks after therapy. A second course may be required to eradicate the infection.

KEY POINTS

Parasites

- Due to the prevalence, morbidity and possible mortality of parasitic conditions, screening as part of a health assessment for all newly arrived refugees is highly recommended.
- Consider screening individuals who have been in Australia for several years, who have not been screened; also screen people returning to Australia from endemic areas.
- Recommended investigations include an FBE (may demonstrate eosinophilia and anaemia) iron studies (may demonstrate low iron stores) serology for schistosomiasis and strongyloides, and faecal microscopy if possible for ova cysts and parasites. Treat as per protocol; careful follow-up is required for schistosomiasis and strongyloides.

Sexually transmitted infections (STIs)

Prevalence

In developing countries, STIs and their complications are among the top five disease categories for which adults seek health care. In women of child-bearing age, STIs (excluding HIV) are second only to maternal factors as causes of disease, death and healthy life lost.[83]

The highest incidence of STIs occurs in the 15–35 year-old age group. Sub-Saharan Africa has the highest annual prevalence of newly diagnosed curable STIs. Sexual violence, poverty, family dislocation and powerlessness all contribute to high STI transmission rates among refugee communities.

STI screening

All refugees including children should undergo screening for syphilis.[64] All adults, sexually active youth and those suspected of being sexually assaulted should have screening for chlamydia and gonorrhoea.[64] Screening should be offered with informed consent, but may be undertaken without taking sexual history. Other investigations should be guided by clinical symptoms and signs.

Women should be offered STI screening in conjunction with well women's checks, Pap smears, mammography and pre-pregnancy counselling when indicated (see Women's health, p.82).

Syphilis

Prevalence

The rate of positive syphilis serology in newly arrived refugees to Western Australia in 2003–04 was 5%.[62] More recent studies show a 1.5% prevalence rate in Burmese refugees in Melbourne.[2]

Transmission

Syphilis may be transmitted sexually or congenitally.

Patterns of illness

Sexually acquired stages of infection include:

- Early infection <2 years includes primary (chancre), secondary (rash or condylomata lata) and early latent disease (asymptomatic)
- Late infection >2 years includes late latent (asymptomatic) and late clinical disease (cardiovascular and neurosyphilis).[63]

Pictures of presenting primary chancres and secondary rashes are available on the Melbourne Sexual Health Centre website www.mshc.org.au/syphilis/pro_home.html.

Congenital infection occurs in 35% of babies born of mothers with syphilis infection of less than 2 years.[30]

Investigations

Pre-arrival syphilis screening is restricted to those over 15 who have lived in camp-like conditions or those suspected to have a STI (see Table 6.1, p.229). Post-arrival screening for syphilis is recommended for all refugees including children. It is also important to screen some clients who have returned from overseas travel.

Screening tests for syphilis are the TPHA, RPR or VDRL.[88] TPHA remains positive for life. RPR is used to monitor disease activity and usually decreases after treatment and with time, even without treatment.

A positive serological diagnosis of syphilis must include:

- positive TPHA and RPR or VDRL serology
- absence of previous syphilis treatment or endemic treponemal disease (e.g. yaws).

Diagnosis of primary infection can be made by microscopic demonstration of spirochaetes on a slide of material from a chancre or mucous membrane with secondary disease (lesions can be cleaned with N saline and air dried onto a slide).

Clients with positive syphilis serology need full STI screening.

Syphilis is a notifiable disease to state and territory health services.

Management

Treatment is usually with benzathine penicillin and is dependent on disease stage. This may be undertaken at the local infectious disease service or in a primary care setting.

National Management Guidelines for Sexually Transmissible Infections produced by the Venereology Society of Victoria are available online: www.mshc.org.au/Portals/6/NMGFSTI.pdf or the Therapeutic Guidelines: Antibiotic Version 14 www.tg.org.au/index.php?sectionid=41.

Follow-up

Follow-up of the RPR or VDRL is important for up to 2 years after initial treatment of uncomplicated syphilis.[88] Retreatment should be considered if there is a sustained four-fold increase in the RPR or the initial RPR fails to fall after 6 months, or clinical signs or symptoms persist.

Gonorrhoea

Transmission

Gonorrhoea is transmitted sexually or perinatally.

Patterns of illness

Gonorrhoea causes cervicitis, pelvic inflammatory disease, infertility, ectopic pregnancy, chronic pelvic pain in women, urethritis, urethral strictures in men and neonatal eye infections. It may also cause rectal infection, arthritis, endocarditis, septicaemia and meningitis or be asymptomatic.

Investigations

First-pass urine PCR is a non-invasive screening test for gonorrhoea. Endocervical or urethral swab for gonorrhoea PCR, gram staining and culture are also recommended if the client is symptomatic.[88]

Gonorrhoea is a notifiable disease.

Management

For current treatment of gonorrhoea, see the National Management Guidelines For Sexually Transmissible Infections produced by the Venereology Society of Victoria at www.mshc.org.au/Portals/6/NMGFSTI.pdf or the Therapeutic Guidelines Antibiotic Version 14 www.tg.org.au/index.php?sectionid=41.

Chlamydia

Transmission

Chlamydia is transmitted sexually and perinatally.

Patterns of illness

Chlamydia is usually asymptomatic but also causes cervicitis, urethritis, pelvic inflammatory disease, infertility, ectopic pregnancy and chronic pelvic pain. In children it can cause pneumonia and conjunctivitis.[89]

Investigations

First-pass urine, endocervical or urethral swab for chlamydia PCR when taking a Pap smear are all suitable screening methods.[88] Non-invasive urine testing is preferable unless the client is symptomatic or undergoing a Pap smear.

Chlamydia is a notifiable disease.

Management

For current treatment of Chlamydia, see the National Management Guidelines For Sexually Transmissible Infections produced by the Venereology Society of Victoria at www.mshc.org.au/Portals/6/NMGFSTI.pdf or the Therapeutic Guidelines Antibiotic Version 14 www.tg.org.au/index.php?sectionid=41.

Helicobacter Pylori (H. Pylori)

Prevalence

Recent data show a 50–80% prevalence rate for H. Pylori in newly arrived refugees (compared to 30% of Australian-born population).[90]

Transmission

Infection usually occurs in childhood via close family contact, possibly through oral and faecal spread, although the exact mechanism is yet to be defined.

Patterns of illness and clinical picture

- Asymptomatic: most H. Pylori infections are asymptomatic, but confer a lifetime risk of peptic ulcer disease of 15% to 20%, and of gastric cancer of up to 2%.[31]
- All people infected appear to develop active chronic gastritis even if asymptomatic.
- Symptomatic: commonly epigastric pain or discomfort, often relieved by antacids, +/– nausea, vomiting and heartburn.
- Because of language and cultural factors, refugee clients may not necessarily describe their epigastric or abdominal discomfort in clinically familiar ways. Because of its high prevalence in countries of origin, it is worth excluding the diagnosis of helicobacter in any client with abdominal symptoms.
- Warning symptoms warranting prompt endoscopy include anaemia, bleeding, weight loss and dysphagia, and age >50 years.
- Children infected with H. Pylori may also display symptoms such as anorexia, early satiety and/or abdominal pain as well as poor weight gain or refractory iron deficiency.[91]
- H. Pylori is present in >90% of duodenal ulcer clients and 80% of gastric ulcer clients.[90]
- H. Pylori gastritis (histologically) is found in about a third of symptomatic clients with no peptic ulcer disease. Many of these clients do improve with eradication therapy, and may then have less risk of recurrent ulcer and cancer.[90]
- Long-term: WHO classifies H. Pylori as a Class 1 carcinogen as it causes chronic atrophic gastritis, which may progress to metaplasia and dysplasia; it is associated with gastric adenocarcinoma, and MALT lymphoma B-cell lymphoma.[90]

Investigations [90]

- Non-invasive:
  - C13- or C14- urea breath test: ingestion of urea labelled with carbon is used in diagnosis and the assessment of eradication therapy. It has reduced sensitivity with acid suppression or antibiotics.
  - C13– is non-radioactive: use in children or women of child-bearing age.
  - Stool antigen test for H. Pylori will diagnose current infection, also reduced sensitivity with proton pump inhibitors/antacids. It may be used in infants and young children but is not funded by MBS, thus at this time is not useful to order in the primary care setting.
- Invasive: histology of gastric biopsies at endoscopy. Rapid urease test on the biopsy.

Serology is not helpful for distinguishing current from past infection.

Screening

Currently there is no recommendation for regular routine screening for H. Pylori in newly arrived asymptomatic refugees.

Management of the symptomatic client

1. Adults under 50 years of age (and where there are no warning symptoms). See Patterns of illness (p.115):

- Perform a urea breath test (C13– in women of child-bearing age – non-radioactive), if positive breath test, eradication therapy: first line comprises triple therapy combining a proton pump inhibitor (PPI) with amoxycillin and clarithromycin.[92] If penicillin allergy, use metronidazole. Failures do occur due to H. Pylori drug resistance, so emphasise to clients the need for compliance.
- Refer for endoscopy if symptoms recur.
- Clients with complicated ulcers, gastric ulcers, ulcers in high-risk groups, NSAID ulcers: continue proton pump inhibitor for 8 weeks.
- Check eradication therapy by repeat stool antigen or C13– or C14– breath test 6–8 weeks after antibiotic course is completed: no antibiotics or bismuth for 1 month prior; if possible cease proton pump inhibitors 2 weeks prior to reduce the chance of false negative results (it is safe to continue H2 receptor antagonists)

If first-line eradication fails, specialist referral is recommended.

2. If warning symptoms present and/or client is over 50, prompt endoscopy and histology and/or rapid urease test for H. Pylori. First degree relatives of clients with gastric cancer, and people born in areas with high gastric or oesophageal cancer prevalence should also have early endoscopy.

3. Children
See Section 5 > Other infections (p.211).

4. Screen for H. Pylori in clients with previously treated peptic ulcer disease – eradication of H. Pylori prevents ulcer relapse.

Refer to a Gastroenterologist (or Paediatrician) if:

- warning symptoms are present (see above)
- first-line eradication therapy fails
- for H. Pylori in children.

Follow-up

Serology is not useful to assess outcome after treatment as antibody levels take a long and variable time to fall.

KEY POINTS

- H. Pylori is a chronic and highly prevalent infection in most countries of origin and transit for refugees.
- If the client has abdominal symptoms, H. Pylori should be excluded by means of a C13– or C14– urea breath test or stool antigen
- Screen for helicobacter in clients with previously treated peptic ulcer.
- Untreated symptomatic helicobacter infection causes significant morbidity with the risk of peptic ulcer bleeding or perforation, and long-term risks of gastric and other cancers.
- Helicobacter infection may cause significant illness in refugee children, and requires specialist consultation.

Immunisation

As many refugee clients may have incomplete immunisation or unsatisfactory records of vaccination, their vaccination status should be reviewed, with clients being offered immunisation according to the recommendations of the National Health and Medical Research Council's The Australian Immunisation Handbook, 9th Edition, which is available online: www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/handbook-home.

Given the rapid change in the immunisation area, it is anticipated that the electronic version of the handbook will periodically be updated to reflect changes. You can access handbook updates here: www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-updates.

Procedures for obtaining prior consent for vaccination are outlined in the NHMRC Handbook and should be followed in the case of both adult and child immunisation. Immunisation of particular relevance to refugee clients is outlined in Table 4.5 (Adults) and Table 5.3 (Children).

Where no documentation or evidence of immunisation is available, consider the following for immunisation catch-up.

TABLE 4.5 Immunisation in refugee clients: Adults

Standard childhood immunisations	Offer primary course (HIB, polio, diphtheria, pertussis, tetanus, measles, mumps, rubella, pneumococcal, varicella, meningococcal C).
Hepatitis B vaccination	Serology recommended (HBsAg, HBsAb,) before vaccination. Provide to: – susceptible household contacts of acute/chronic carriers – susceptible sexual partners of carriers/acute Hep B plus Hep B Ig.
BCG	Not routinely recommended.
	Consult your state/territory TB program.
Rubella	Offer MMR to all seronegative women child-bearing age. Must not be pregnant or planning pregnancy for 1 month.
Adult diphtheria/ tetanus	Required only at age 50 years if childhood immunisations complete.

The Quick Guide to Catch-Up Immunisation has been developed for Victorian immunisation providers. It is a simple schedule of catch-up immunisations for people presenting with no immunisation and is useful to help ensure that people are immunised appropriately and recalled in a timely manner for their next immunisations. See Quick Guide Catch-Up Immunisation for Victoria www.health.vic.gov.au/immunisation/quick-guide-catch-up.htm.

Chronic disease

Chronic diseases, such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are by far the leading cause of mortality in the world, representing 60% of all deaths. Chronic stress, malnutrition, lack of preventive care and lack of early diagnosis suggest that these conditions are surprisingly common in newly arrived refugees, especially older clients. Language and cultural barriers, low educational background and literacy, social isolation, lack of transport and scarcity of interpreters in some newly emerging languages also mean that these common conditions may be harder to treat and have increased morbidity and mortality in the refugee population. Australia's humanitarian entrants are diverse, and there may be differences in response to commonly prescribed medication for chronic disease. The concept of preventive care, for example taking an anti-hypertensive long-term to prevent end-organ damage, or the benefits of exercise and physiotherapy for chronic arthropathies, may not be well understood and may require careful explanation.

Common chronic disease presentations seen in primary care, and links to key national websites, are:

- Diabetes: Diabetes Australia www.diabetesaustralia.com.au
- Cardiovascular Disease: Heart Foundation www.heartfoundation.com.au
- Arthritis: Arthritis Australia www.arthritisaustralia.com.au
- Cancer: The Cancer Council Australia www.cancer.org.au
- Asthma and COPD: National Asthma Council Australia; COPD-X www.copdx.org.au/home www.nationalasthma.org.au.

Chronic diseases in refugees

The World Health Organization has listed the four main chronic diseases (or 'non-communicable' diseases) as cardiovascular disease, cancer, chronic lung disease and diabetes, stating that these are in fact the leading cause of death across the world. Approximately one-third of those dying of chronic diseases are under 60, and 90% of these premature deaths occurred in low- and middle-income countries.[93]

Newly arrived refugees may be suffering from chronic diseases that were undiagnosed or untreated in their country of origin (or transit) due to: (1) the paucity of affordable or effective medical care and/or, (2) a lack of chronic disease screening or prevention programs in some countries. Chronic stress, malnutrition and a lowered immune system may also contribute to the possible development of some chronic diseases.

However, once in Australia, the situation often does not improve. Language and cultural barriers, low educational background and literacy, poverty and resettlement stressors, social isolation, lack of transport and scarcity of interpreters in some newly emerging languages also means that these common conditions may be harder to diagnose and treat; self-management may be harder to explain and encourage; and thus chronic diseases may result in increased morbidity and mortality in the refugee population. More research is needed into the prevalence of chronic disease in this vulnerable group.

The research that exists shows that there are considerable risks for particular groups of refugees. A recent study of 459 refugee psychiatric patients found the prevalence of hypertension and diabetes to be 42.0% and 15.5% respectively.[47] This was significantly higher than US norms and was especially pronounced in people younger than 65 years.[94]

Mental health concerns in refugee patients may make optimal management of chronic diseases, such as diabetes, more complex (see Section 3, p.45).

Investigations

Consider chronic disease screening during the refugee health assessment (record smoking habits, alcohol intake, BMI, blood pressure) (see Section 6, p.227); consider lipids, fasting glucose and eGFR, particularly if the patient is overweight, obese or hypertensive. Offer mammography and Pap smears to women, taking time to carefully explain these tests. Patients who are hepatitis BsAg positive or hepatitis C positive should be referred as per national guidelines. Faecal occult blood screening may be offered to those over 50.

Patients of refugee background should continue to be screened for the development of chronic disease as they may be at increased risk for the reasons outlined above. Modifiable risk factors and the diseases themselves, if present, often require detailed and repeated explanation. It is helpful to use pictorial information in those with low literacy, and information (where available) in the patient's preferred language. This is not always easy to source, and requires ongoing government investment. See Section 10 (p.316) for web links to pictorial information for clients.

Good recall systems, a family-centred and coordinated healthcare team approach may assist in the management of the individual patient, while efforts focussed on community engagement, education and empowerment may ultimately provide the best long-term prevention strategy.

RESOURCES

The Royal Australian College of General Practice guidelines Preventive Activities in General Practice ('the red book') 2009; Putting Prevention into Practice ('the green book') 2nd edition; and SNAP: A Population Health Guide to Behavioural Risk Factors in General Practice are all available online at www.racgp.org.au/guidelines.

'An evaluation of the primary healthcare needs of refugees in south east metropolitan Melbourne': a report by the Southern Academic Primary Care Research Unit (SAPCRU) to the Refugee Health Research Consortium, prepared in 2011, identifies a number of focus areas for primary health care, with a focus on the distinct needs of different refugee subpopulation groups. It suggests that some people who arrived through the humanitarian program from the Former Yugoslavia experience higher rates of circulatory diseases and cancer, and have higher chronic disease needs compared to other refugee and Australian-born residents. To read the report visit the SAPCRU website: http://sapcru.org/services/consulting/.

Cardiovascular disease

The World Health Organisation (WHO) uses this term to refer to coronary heart disease, cerebrovascular disease, peripheral arterial disease, rheumatic and congenital heart disease, deep vein thrombosis and pulmonary embolism. In newly arrived refugees, consider undiagnosed congenital heart disease and rheumatic heart disease.

Behavioural risk factors cause about 80% of coronary heart disease and cerebrovascular disease. The main factors are: an unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol. These may lead to the metabolic risk factors of raised blood pressure, glucose and lipids, as well as weight gain and obesity.[95]

Underlying factors include globalisation, urbanisation, and population ageing, as well as poverty, stress and hereditary factors.

People in low- and middle-income countries experience more risk factors for cardiovascular disease, and have less exposure to prevention programs and effective detection and treatment. Thus many sufferers die young, contributing to the ongoing poverty and affliction of their families.

Cardiovascular disease risk can be reduced by regular physical activity, avoiding tobacco use and second-hand tobacco smoke, eating fruit and vegetables, avoiding foods that are high in fat, sugar and salt, and keeping a healthy body weight.[95]

RESOURCES

Royal Australian College of General Practitioner Guidelines: www.racgp.org.au/guidelines/lipids.

The Australian Heart Foundation website has information for healthcare practitioners on lipids and hypertension management. www.heartfoundation.org.au/information-for-professionals/Clinical-Information/Pages/default.aspx.

Diabetes

Both Type 1 and Type 2 Diabetes (which comprises 90% of the world's diabetes burden), as well as gestational diabetes and impaired fasting glucose are prevalent in the low- and middle-income countries from which Australia's humanitarian entrants arrive. The WHO projects that diabetes deaths will double in these countries between 2005 and 2030.[96]

The same risks and prevention strategies apply to Type 2 Diabetes as to cardiovascular disease. Type 1 diabetes is not currently preventable.

Screening and early diagnosis of diabetes, followed by good blood glucose control and effective management of coexisting metabolic conditions (such as hypertension) are the key to prevent the serious consequences of retinopathy, cardiovascular and cerebrovascular disease, peripheral neuropathy, amputation, chronic lower limb infections, renal disease and renal failure.

RESOURCES

Australian guidelines on Diabetes Management in General Practice (17th edn) and Chronic Kidney Disease (CKD) Management in General Practice as well as other resources can be found on the RACGP website www.racgp.org.au/guidelines/diabetes.

CLIENT INFORMATION IN CLIENT LANGUAGES

The following websites provide information in many client languages about chronic disease diabetes, diabetes management, diet and nutrition:

- Health Translations:
  - Diabetes healthtranslations.vic.gov.au/bhcv2/bhcht.nsf/PresentEnglishResource?Open&x=&s=Diabetes
  - Chronic Obstructive Pulmonary Disease healthtranslations.vic.gov.au/bhcv2/bhcht.nsf/PresentEnglishResource?Open&x=&s=Smoking.
- Diabetes Victoria www.diabetesvic.org.au/order-publications?view=publicationsshop.
- QUIT www.quit.org.au/multicultural.aspx
- The Better Health Channel www.betterhealth.vic.gov.au

For more resources see Section 10 (p.318).

Cancer

70% of cancer deaths occur in low- and middle-income countries. Lung, stomach, liver, colon and breast cancer cause the most cancer deaths each year. About 30% of cancer deaths are due to the five leading behavioural and dietary risks: high body mass index, low fruit and vegetable intake, lack of physical activity, tobacco use and alcohol use. Other factors include chronic infections from hepatitis B (HBV), hepatitis C virus (HCV) and some types of human papilloma virus (HPV) especially in low- and middle-income countries. See Hepatitis B (p.136) and Hepatitis C (p.138). Cervical cancer due to HPV is a leading cause of cancer death among women in low-income countries.

RESOURCES

Guidelines for health professionals are available on the Cancer Council of Australia's website: www.cancer.org.au/Healthprofessionals/PrimaryCareResources.htm.

Chronic obstructive pulmonary disease

Nearly 80% of the world's 1 billion smokers come from low- and middle-income countries. Over 40% of children have at least one smoking parent.

Some evidence suggests that as a result of settlement stress some individuals may increase their tobacco intake. Consultations should focus on preventive measures including smoking cessation, reduced alcohol intake, healthy diets and increased physical activity (see Nutrition, p.104).

RESOURCES

The Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease and other resources are available from the COPD-X Plan site www.copdx.org.au.

CASE STUDY

Mary arrived in Australia as a refugee 10 years ago with her three daughters. She attends the local community health service but has seen many GPs in the local area. She speaks good but idiosyncratic English. She was a child soldier in her country of origin, and has a long history of trauma, which included the bombing death of one of her children, the loss through war of most family members, and witnessing the traumatic deaths under fire of many of her military comrades. She has chronic arthropathies related to war injuries and has been unable to get these satisfactorily addressed. She has also recently been diagnosed with hypertension and non-insulin dependent diabetes mellitus (NIDDM). When distressed about her housing or Centrelink issues she does not show up to appointments to manage her diabetes. She finds it hard to record her blood glucose as she is semi-literate.

Torture and trauma injuries

While torture produces longstanding psychological issues, many of the techniques used are mediated by severe physical damage from beatings, suspension, enforced and sustained extreme positions, burning and electrical torture. These can produce significant tissue damage and ongoing pain and physical injury. Physical injuries may involve all organ systems, though symptoms and physical findings will vary in a given organ system over time. The effects may be acute or chronic and may include psychosomatic or neurological symptoms. Musculoskeletal symptoms are commonly present in both acute and chronic phases. A particular method of torture or injury, its severity and anatomical location will indicate the likelihood of specific physical findings. Some common presentations are:

- fractures and soft tissue damage
- subcutaneous fibrosis and compartment syndrome of the feet may have resulted from beating of the soles of the feet
- highly characteristic skin changes may have resulted from the use of electricity and various methods of burning
- pattern of scars may have resulted from whipping
- musculoskeletal and nerve injuries from body stretching and suspension
- pain and sexual dysfunction from trauma to the genitals and sexual assault
- organic brain dysfunction from beating to the head and loss of consciousness.

Psychological and physical interaction issues

The symptoms in the survivor of torture may be somatic, psychological or psychosomatic. Reasons for the tendency of survivors of torture to somatise may be due to the torture or other factors such as geography or culture.[97]

CHRONIC PAIN: A PHYSIOTHERAPY PERSPECTIVE

Many survivors of torture and trauma present with longstanding pain over the cervical, thoracic and lumbar spinal regions. In one study of 21 male survivors of physical and psychological torture and trauma assessed in Denmark 67% suffered from headaches and 81% satisfied the criteria for fibromyalgia.[98] Chronic low back and neck pain have been related to altered function of lumbar and cervical musculature.[99, 100] Recent evidence suggests changes in brain function and even structure in the presence of chronic pain, which may add to altered body perception, increased effect of noxious stimuli and psychological dysfunction. These findings may assist in development of possibilities in the management of chronic pain conditions.[101]

One such possibility is a pain neuromatrix approach for treating patients with chronic pain. This approach views persistent pain as related to an enlarged and diversified recognition of threatening stimuli, not only nociceptive but also 'cognitive–evaluative', by the brain with a resultant change in motor output.[102] The therapeutic approach is to focus on reduction of this threat via education and progression of motor and functional tasks. There is some evidence to suggest that there are benefits to explaining pain in detail, including its neurophysiology, in order to increase understanding in patients.[103] However, more research on this approach is needed.

A second possibility in the treatment of survivors of torture and trauma involves physiotherapy in conjunction with psychotherapy. Danneskiold-Samsoe et al. have reported significant reduction in muscle pain experienced in survivors of torture and trauma clients with fibromyalgia following a 9 month combined physiotherapy and psychotherapy treatment program.[100] This suggests benefits of physiotherapy conducted within a multidisciplinary setting for this client group. Further research is required to build on these findings.

On a more individual level many of the aspects of physiotherapy for survivors of torture attest to the release of self-healing when physical therapies are applied, although the first session often involves no contact until a trusting relationship can be established. In some cultures, for example with Balkan folk healing, the importance of a relationship of trust in facilitating communication and healing is emphasised.[104]

Touch forms the basis of a significant aspect of assessment, such as in the evaluation of muscle tension and articular dysfunction,[105] as well as the basis of many treatment alternatives. Lack of care in touch and positioning may create a potential stressor for the survivor of torture.[106] In view of the likelihood of sexual torture particularly with women, touch around the pelvis or lumbar spine needs particular care. There may also be cultural expectations about gender roles, which may be magnified by the intimate nature of physiotherapy, which can have a significant impact on the treatment and management of clients.

The relationship between psychological distress (e.g. depression and anxiety) and reduced coping feelings in those with ongoing pain, can distort the influence emotions can have on pain perception and memory. This link may need to be tactfully discussed with the client, combined with 'appropriate attention to psychophysical techniques of pain reduction, such as education and relaxation strategies', and is a necessary link for the physiotherapist to understand, to ensure diagnostic accuracy.[107]

> "In order to understand, and to believe in the reality of someone else's pain, we must understand the language of pain used by that person, the idiom of distress which is meaningful to the person and his culture." [108]

Chronic pain and psychosomatic disorders

Psychosomatic disorders and chronic pain in refugee clients are very common presentations in primary care. Psychosomatic presentations may not simply encompass pain but also other unusual symptoms. Often long periods (even years) may elapse, between the trauma to when the client is seen by the healthcare practitioner. Physical injuries due to torture and trauma are frequently interrelated with physical deprivation, language and cultural barriers as well as resettlement difficulties – the interaction of which creates complex management issues.

With any client with longstanding pain establish whether its chronicity is due to previous inadequate assessment and treatment. Appropriate management may then yield good results despite the time delay. However in many cases a more holistic approach is required.

Diagnoses to consider

- Vitamin D deficiency
- Infectious diseases (e.g. bone TB, syphilis, schistosomiasis)
- Inflammatory and/or osteoarthritis
- Soft tissue damage due to torture, accidents
- Cancer
- Congenital abnormalities.

Management principles

- Establish rapport over time. Take the time to gently elicit some of the client's story. A useful question: 'What do you think caused the pain?' 'What was happening to you/your family at the time you first noticed the pain?'
- Avoid an interrogative style. See Section 3 (p.45) for further advice.
- In many cases a sympathetic detailed hearing of a client's story of their chronic pain can be a relief to the client.
- It is vital to use a trained professional interpreter in both medical and allied health settings, to elicit a clear history of the pain, its meaning to the client, and to enable the health practitioner to discuss the management plan with the client.
- The reassurance of a full physical examination and targeted investigations (performed with the client's understanding and consent) may be very helpful (e.g. a bone scan for chronic bone pain rather than X-ray may demonstrate previous trauma).
- Chronic pain may impair sleep, which then creates a negative cycle of chronic pain, poor sleep, day-time fatigue, irritability and lowered mood.
- To attempt to relieve their pain, some clients may over-use common analgesics, such as paracetamol, or paracetamol–codeine preparations. It is important to try to find out exactly what the client is taking, and to liaise with their pharmacist if necessary to ensure the client's understanding of, and compliance with, medication.
- Pain may also affect resettlement (e.g. the ability to access and attend English classes; may place limitations on available housing; and increase social isolation).

A holistic, case conference approach using physiotherapy, podiatry, occupational therapy as appropriate, may help to prevent confusion and reassure the client that the team will be involved in their health care.

It is often frustrating for a refugee client to be told that there is 'nothing wrong' with them. Their cultural background, previous education and lack of medical experience may mitigate against acceptance of a Western, medical–psychological explanation. It is better to explain that, although the investigation results are normal, their pain is real. It is often helpful to explain that the health professional will seek to analyse the client's movement restrictions, with treatment/management focussed on improving these, and as this improvement in restriction occurs, often their pain will begin to be reduced.

Complementary therapies provided by therapists specially trained in the care of torture and trauma survivors will be invaluable. However, consider cost when referring to private therapists.

See Section 7 > Complementary Therapies (p.276).

A chronic pain clinic may be of assistance, but long waiting lists and inexperience in dealing with refugee clients may be an issue.

Attending to concomitant factors, such as the client's real concerns about housing, access to language classes, schooling and social isolation can play a vital role in resettlement, stress reduction and consequently, allay psychological anxiety and physical symptoms.

"

"I feel sick and they said there's nothing that they've found in my body."
"There is a reason why my head hurts, there's a reason why my back hurts but if they don't detect anything there has to be a solution."

References

1. Johnston, V., Smith, L. & Roydhouse H. (2011). 'The health of newly arrived refugees to the Top End of Australia: results of a clinical audit at the Darwin Refugee Health Service'. Australian Journal of Primary Health, published online December 2011. < dx.doi.org/10.1071/PY11065 >
2. Chaves, NJ., Gibney, KB., Leder, K., O'Brien, DP., Marshall, C. & Biggs, B-A. (2009). 'Screening practices for infectious diseases among Burmese refugees in Australia'. Emerging Infectious Diseases, (15)11, 1769-72.
3. Webster, K. & Kaplan, I. (2003). 'Refugee Women and Settlement: Gender and Mental Health' in Allotey, P. (ed.) The Health of Refugees: Public Health Perspectives from Crisis to Settlement. Oxford University Press.
4. Biotechnology Australia. (2007). 'Testing and Pregnancy'. Genetics in Family Medicine: The Australian Handbook for General Practitioners, Biotechnology Australia. Retrieved from: < http://www.gpgenetics.edu.au >.
5. Rintoul, A. (2009). Understanding the mental health and wellbeing of Afghan women in SE Melbourne, Victoria: Foundation House, p.22.
6. World Health Organization (WHO) (2010). Female Genital Mutilation, Fact sheet No. 241.Geneva: WHO. Retrieved from: < www.who.int/mediacentre/factsheets/fs241/en >.
7. The Royal Australian College of Obstetricians and Gynaecologists (1997). 'Female Genital Mutilation: Information for Australian Health Professionals'. Melbourne. Retrieved from: < www.ranzcog.edu.au/publications/womens-health-publications/female-genital-mutilation-fgm-booklet.html >.
8. Mathews, B. (2011). Female genital mutilation: Australian law, policy and practical challenges for doctors. Medical Journal of Australia, 194(3), 139-141.
9. Byrne, M. (2006). The Other 50%: Refugee Men's Health NSW Refugee Health Service, Sydney. See also: NSW Refugee Health Service. (2009). Fact Sheet 9: Refugee Men. Retrieved from: < www.sswahs.nsw.gov.au/sswahs/refugee/pdf/Resource/FactSheet/FactSheet_09.pdf >.
10. Correa-Velez, I & Gifford, S. (2011). Health and settlement among men from refugee backgrounds living in South East Queensland, La Trobe Refugee Research Centre, La Trobe University. Retrieved from: < www.latrobe.edu.au/__data/assets/pdf_file/0009/144945/Correa-Velez,-et-al.-SettleMen-WEB.pdf >.
11. McMichael, C., Gifford, S.M. & Correa-Velez, I. (2011). 'Negotiating family, navigating resettlement: family connectedness amongst resettled youth with refugee backgrounds'. Journal of Youth Studies, 14(2), 179-195(17).
12. Williams, N. (2011). 'A Critical Review of the Literature: Engendering the Discourse of Masculinities Matter for Parenting African Refugee Men'. American Journal of Men's Health, 5(2), 104-117.
13. Sowey, H. (2005). Are Refugees at Increased Risk of Substance Misuse? Redfern, Australia: Drug and Alcohol Multicultural Education Centre (DAMEC).
14. De La Rosa, M. & Adrados, J. (eds.) (1993). Drug Abuse Among Minority Youth: Advances in Research and Methodology. National Institute on Drug Abuse (NIDA) Research Monograph. US Department of Human Services No. 130, Retrieved from: < http://archives.drugabuse.gov/pdf/monographs/download130.html >.
15. Goren, N. (2006). Prevention, newly arrived refugees and substance misuse. Drug Information Clearing House. June (18). Retrieved from: < www.druginfo.adf.org.au/article.asp?ContentID=refugees_eval_report >.
16. Davidson, N., Skull, S., Calache, H., Murray, S. & Chalmers, J. (2006). 'Holes a plenty: oral health status a major issue for newly arrived refugees in Australia'. Australian Dental Journal, 51(4), 306-311.
17. Kingsford Smith, D. & Szuster, F. (2000). 'Aspects of tooth decay in recently arrived refugees'. Australian and New Zealand Journal of Public Health, 24(6), 623-626.
18. Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M...& Lavanya, N. (2011). 'Evidence-based clinical guidelines for immigrants and refugees'. Canadian Medical Association Journal, Volume, E1-E102.

19. Victorian Foundation for Survivors of Torture. (2001). Service Usage Data. Victoria: Victorian Foundation for Survivors of Torture.
20. Lamb, CE., Whelan, AK. & Michaels, C. (2009). 'Refugees and oral health: lessons learned from stories of Hazara refugees'. Australian Health Review, 33(4), 618-627.
21. Mariño, R., Calache, H., Wright, C., Morgan, M., Schofield, SM. & Minichiello, V. (2007). 'Profile of oral health among ambulant older Greek and Italian migrants living in Melbourne'. Australian Dental Journal. 52(3), 198-204.
22. Sheikh-Mohammed, M., MacIntyre, CR., Wood, NJ., Leask, J. & Isaacs, D. (2006). 'Barriers to access to healthcare for newly resettled sub-Saharan refugees in Australia'. Medical Journal of Australia. 185(11/12), 594-597.
23. Davidson, N., Skull, S., Calache, H., Murray, S. & Chalmers, J. (2006). 'Holes a plenty: oral health status a major issue for newly arrived refugees in Australia'. Australian Dental Journal, 51(4), 306-311.
24. Victorian Refugee Health Network. (2012). Fact Sheet: Refugee Oral health: Working with clients from refugee and asylum seeker background. Accessible on the Victorian Refugee Health Network < www.refugeehealthnetwork.org.au >. [to be released March 2012].
See also: Victorian Refugee Health Network. (2012). Fact Sheet: Refugee Oral health: Identifying clients from refugee and asylum seeker background. Accessible on the Victorian Refugee Health Network < www.refugeehealthnetwork.org.au >. [to be released March 2012].
25. Oral health messages for the Australian public. (2011). 'Findings of a national consensus workshop'. Australian Dental Journal, 56, 331-335.
26. Information on diet, nutrition and lifestyle issues has been obtained from the Food and Nutrition Project for Recent Arrivals from Refugee Backgrounds. This was a project of the Victorian Foundation for Survivors of Torture (VFST) in collaboration with Deakin University and Darebin, Springvale and Western Region Community Health Centres and funded by the Victorian Health Promotion Foundation in 2006.
27. Joint statement by the World Health Organization, the World Food Programme and the United Nations Children's Fund (2007). Preventing and controlling micronutrient deficiencies in populations affected by an emergency. Geneva. Retrieved from: < http://www.who.int/nutrition/publications/WHO_WFP_UNICEFstatement.pdf >.
28. Southcombe, F. (2008). 'We buy food if there is money left from rent and bills, but thre is no money left'. Discussion paper and presentation. Fairfield Nutrition Project. Retrieved from: < http://www.ncoss.org.au/bookshelf/conference/download/perspectives_on_poverty/faye-southcombe-oct07.pdf >.
29. Gallegos, D., Ellies, P. & Wright, J. (2008). 'Still there's no food! Food insecurity in a refugee population in Perth, Western Australia'. Nutrition and Dietetics, 65, 78-83.
30. Fauci, AS., Braunwald, E., Kasper, DL., Hauser, SL., Longo, DL., Jameson, JL. & Loscaizo, J. (2008). Harrison's Online: Harrison's Principles of Internal Medicine (17thedn). USA: Online McGraw-Hill.
31. Therapeutic Guidelines Ltd. (2011). Therapeutic Guidelines: Gastrointestinal, Version 5. North Melbourne. Accessible online: < www.tg.org.au.
32. Baines, S. & Roberts, D. (2001). 'Undernutrition in the community'. Australian Prescriber, 24(5), 113-5. Retrieved from: < www.australianprescriber.com/magazine/24/5/113/5/ >.
33. Osteoporosis Australia (2006). Calcium, vitamin D and osteoporosis – a guide for GPs. Caberra: Australian Government Department of Health and Ageing. Retrieved from: < www.osteoporosis.org.au/files/GP%20guide%20vit%20D%20%20calcium%20final.pdf >.
34. Victorian Department of Health. (2010). Low Vitamin D. Key health messages for doctors, nurses and allied health, May. Retrieved from: < http://www.health.vic.gov.au/chiefhealthofficer/downloads/vitamin_d_med2010may.pdf >.
35. Working Group of the Australian and New Zealand Bone and Mineral Society, Endocrine Society of Australia and Osteoporosis Australia. (2005). 'Vitamin D and adult bone health in Australia and New Zealand: a position statement'. Medical Journal of Australia, March 21, 182 (6),281–5.
See also: Osteoporosis Australia. (2006). op cit.

36. Skull, S., Ngeow, J., Biggs, B-A., Street, A. & Ebeling, PR. (2003). 'Vitamin D deficiency is common and unrecognized among recently arrived adult immigrants from the Horn of Africa'. International Medical Journal, 33(1-2), 47–51.
37. McGillivray G., Skull SA., Davie G., Kofoed, SE., Frydenberg, A., Rice, J...& Carapetis, JR. (2007). 'High prevalence of asymptomatic vitamin D and iron deficiency in East African immigrant children and adolescents living in a temperate climate'. Archive of Disease in Childhood, 92, 1088-93. Doi:10.1136/adc.2006.112813
38. Johnson, D. (2007). Rates of infectious diseases and nutritional deficiencies in newly arrived African refugees. Central North Adelaide Health Service, Government of South Australia. Retrieved from: < www.sdgp.com.au/client_images/107719.pdf >.
39. Benitez-Aguirre PZ., Wood NJ., Biesheuvel C., Moreira C., & Munns, CF. (2009). 'The natural history of vitamin D deficiency in African refugees living in Sydney'. Medical Journal of Australia, 190, 426-8.
40. Gray K., Wood N., Gunasekera H., Sheikh, M., Hazleton, B., Barzi, F. & Isaacs, D. (2011). 'Vitamin D and Tuberculosis Status in Refugee Children'.Pediatric Infectious Diseases Journal. [post acceptance 23 December 2011].
41. Sheikh, M., Pal, A., Wang, S., MacIntyre, CR., Wood, NJ., Isaacs, D...& Howell, A. (2009). 'The epidemiology of health conditions of newly arrived refugee children: a review of patients attending a specialist health clinic in Sydney'. Journal Paediatrics and Child Health, 45(9), 509-13.
42. Bowyer, L., Catling-Paull, C., Diamond, T., Homer, C., Davis, G. & Craig, M.E. (2009). 'Vitamin D, PTH and calcium levels in pregnant women and their neonates'. Clinical Endocrinology (Oxf), March 70(3), 372-7.
43. Grover, SR. & Morley, R. (2001). 'Vitamin D deficiency in veiled or dark skinned pregnant women'. Medical Journal of Australia, 171, 251-2.
44. Judkins, A., & Eagleton, C. (2006). 'Vitamin D deficiency in pregnant New Zealand women'. New Zealand Journal of Medicine, 119, U2144.
45. Paxton, GA., Sangster, KJ., Maxwell, EL., McBride, CRJ. & Drewe, RH. (2012). 'Post arrival health screening in Karen refugees in Australia'. Submitted for publication 2011.
46. Tiong, ACD., Patel, MS., Gardiner, J., Ryan, R., Linton, KS, Scopel, J. & Biggs, B-A. (2006). 'Health issues in newly arrived African refugees attending general practice clinics in Melbourne'. Medical Journal of Australia, Dec 4-18, 185(11/12), 602-606.
47. Therapeutic Guidelines Limited (2009), eTherapeutic Guidelines: Endocrinology, version 4. Accesible at: < www.tg.com.au.
48. Royal Women's Hospital. (2006). Clinical Practice Guidelines Vitamin D: Antenatal Screening. Retrieved from: <www.thewomens.org.au/VitaminDAntenatalScreening?searchTerms[]=Clinical&searchTerms[]=Practice&searchTerms[]=Guidelines&searchTerms[]=Vitamin&searchTerms[]=D-&searchTerms[]=Antenatal&searchTerms[]=Screening >.
49. Cherian, S., Forbes, DA., Cook, AG., Sanfilippo, FM., Kemna, EH., Swinkels, DW., Burgner, DP. (2008). 'An Insight into the Relationships between Hepcidin, Anemia, Infections and Inflammatory Cytokines'. Pediatric Refugees: A Cross-Sectional Study, PLoS ONE 3 (12), e4030. doi:10.1371/journal.pone.0004030
50. See also: Tiong et al. (2006) op cit.
51. Pasricha, S-R., Flecknoe-Brown, SC., Allen, KJ., Gibson, PR., McMahon, LP., Olynyk, JK...& Robinson, KL. (2010). 'Diagnosis and management of Iron Deficiency Anaemia: a clinical update'. Medical Journal of Australia, Nov 1, 193(9), 525-32.
52. Murtagh, J. (2011). General Practice (5th edn.). McGraw-Hill Medical Publishing, Australia.
53. Haddy T., Rana S. & Castro, O. (1999). 'Benign ethnic neutropaenia: what is a normal absolute neutrophil count'. Journal of Laboratory and Clinical Medicine, Jan, 133(1), 15-22.
54. Royal College of Pathologists of Australasia (RCPA) (2004). RCPA Manual, Version 4.0, 12 March. Retrieved from: < www.rcpamanual.edu.au/sections/pathologytestindex.asp?s=33 >.
55. World Health Organization (WHO) (2006). Thalassaemia and other haemoglobinopathies: Report by the Secretariat. EB 118/5, Geneva: WHO. Retrieved from: < www.who.int/gb/ebwha/pdf-files/EB118/B118_5-en.pdf >.

56. Bowden, DK. (2001). 'Abnormal Laboratory Results: Screening for thalassaemia'. Australian Prescriber, 24(5), 120-123. Retrieved from: < www.australianprescriber.com/upload/pdf/articles/540.pdf >.
57. Royal Women's Hospital. (2004). Clinical Practice Guidelines – Thalassaemia and Abnormal Haemoglobins in Pregnancy. Retrieved from: < http://www.thewomens.org.au/MaternityClinicalPracticeGuidelines?printView=true >.
58. Sickle Cell Society London. (2004). Information for Health Professionals. Retrieved from: < http://www.sicklecellsociety.org/websites/123reg/LinuxPackage22/si/ck/le/sicklecellsociety.org/public_html/resources/view/7 >
59. Yong, KM., Marshall, CL.,& Eisen, D. (2007). 'Tropical pulmonary eosinophilia: a rare cause of cough in immigrants to Australia'. Medical Journal of Australia, 187 (7): 416-418. Retrieved from: < www.mja.com.au/public/issues/187_07_011007/yon10226_fm.html >.
60. Sahr, F., Hazra, PK. & Grillo, TA. (1995). 'White blood cell count in healthy Sierra Leoneans'. West African Journal of Medicine, Apr-Jun, 14(2), 105-7.
61. World Health Organization (WHO). (2011). World Malaria Report 2011. Geneva: WHO. Pp.72-28. Retrieved from: < www.who.int/malaria/world_malaria_report_2011/9789241564403_eng.pdf >.
62. Johnson, D. (2007). Rates of infectious diseases and nutritional deficiencies in newly arrived African refugees. Central North Adelaide Health Service, Government of South Australia. Retrieved from: < www.sdgp.com.au/client_images/107719.pdf >.
63. Martin, JA., Mak, DB. (2006). 'Changing faces: a review of infectious disease screening of refugees by the Migrant Health Unit, Western Australia in 2003 and 2004'. Medical Journal of Australia, Dec 4-18, 185(11/12), 607-610.
64. Victorian Department of Human Services (DHS) (2005). The blue book: Guidelines for the control of infectious diseases. DHS Communicable Diseases Section, 1–270. Retrieved from: < http://docs.health.vic.gov.au/docs/doc/FE2665DB66894C46CA2578B0001BE87E/$FILE/bluebook.pdf >.
65. Australasian Society for Infectious Disease (2009). Diagnosis, Management and Prevention of Infections in recently arrived refugees. Sydney: Dreamweaver Publishing. Retrieved from: < www.asid.net.au/downloads/RefugeeGuidelines.pdf >.
66. Benson, J. (2007). 'Malaria in the Australian refugee population'. Australian Family Physician, September 28 (3), . Retrieved from: < http://www.racgp.org.au/Content/NavigationMenu/Publications/AustralianFamilyPhys/2007issues/afp2007august/200708benson.pdf >.
67. Brewin, P., Jones, A., Kelly, M., McDonald, M., Beasley, E., Sturdy, P...& Griddiths, C. (2006). 'Is screening for tuberculosis acceptable to immigrants? A qualitative study'. Journal of Public Health, Sep, 28(3), 253-60. Retrieved from: < http://jpubhealth.oxfordjournals.org/content/28/3/253.full.pdf+html .
68. Department of Immigration and Citizenship (DIAC) (2010). Fact Sheet 22 – The Health Requirement. DIAC. Retrieved from: < http://www.immi.gov.au/media/fact-sheets/22health.htm >.
69. Core Working Party for Asia-Pacific Consensus on Hepatitis B and C. (2000). 'Consensus statements on the prevention and management of hepatitis B and hepatitis C in the Asia-Pacific region'. Journal of Gastroenterology and Hepatology, August, 15(8), 825-41.
70. Arafa, N., El Hoseiny, M., Rakacewicz, C., Bakr, I., El-Kafrawy, S., El Daly, M...&Fontanet, A. (2005). 'Changing pattern of hepatitis C virus spread in rural areas of Egypt'. Journal Of Hepatology, Septmber, 43(3), 418-424.
71. Caruana, SR., Kelly, HA., Ngeow, JYY., Ryan, NJ., Bennett, CM., Chea, L... & Biggs, B-A. (2006). 'Undiagnosed and potentially lethal parasitic infections among immigrants and refugees in Australia'. Journal of Travel Medicine, July-Aug, 13(4), 233-239.
72. Roberts, A. & Yeung, L. (2002). 'Maternal-infant transmission of hepatitis C virus infection'. Journal Of Hepatology, 36(5), S106-S113.
73. Ferrero, S., Lungaro, P., Bruzzone, BM., Gotta, C., Bentivoglio, G, Ragni, N. (2003). 'Prospective study of mother-to-infant transmission of hepatitis C virus: a 10-year survey (1990-2000)'. Acta Obstetricia Et Gynecologica Scandinavica, 82(3), 229-234.

74. Negro, F. & Alberti, A. (2011) 'The global health burden of hepatitis C virus infection'. Liver International. 31(s2), 1-3.
75. Chen, SL. & Morgan, TR. (2006). 'The natural history of hepatitis C (HCV) infection'. International Medical Journal, 3(2), 47-52.
76. Hoefs, J. & Aulakh, VS. (2006). 'Treatment of chronic HCV infection in special populations'. International Journal of Medical Science, 3(2), 69-74.
77. Joint United Nations Programme on HIV/AIDS (UNAIDS) (2011). Global HIV/AIDS Response. Epidemic update and health sector progress towards Universal Access, Progress Report 2011. UNAIDS, Geneva. Retrieved from: < www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20111130_UA_Report_en.pdf >.
78. Biggs, B-A., Lemoh, C., Hellard, M. & Street, A. (2006). Reducing the risk of transmission of HIV/AIDS in African and Arabic-speaking communities in Victoria. Department of Medicine, The University of Melbourne. Retrieved from: < http://www.cmy.net.au/Assets/226/1/DHS_HIVAIDSinVictoria_CommunityReport.pdf >.
79. Mandell, G., Bennett, J. & Dolin, R. (2010). Mandell, Douglas and Bennett's principles and practice of infectious diseases. (7th ed). Philadelphia London, Churchill Livingstone.
80. Hoy, J. & Lewin, S. eds. (2004). HIV management in Australasia: A guide to clinical care. Sydney, Australasian Society for HIV Medicine.
81. Kwon, JA., Yoon, SY., Lee, CK., Lim, CS., Lee, KN. & Sung HJ. (2006). 'Performance evaluation of three automated human immunodeficiency virus antigen-antibody combination immunoassays'. Journal Of Virological Methods, 133(1), 20-26.
82. Keynan, M. (2004). Late HIV presentation among African communities. Sydney, Multicultural HIV/AIDS and Hepatitis C Service: W3-4.
83. de Silva, S., Saykao, P., Kelly, H.,MacIntyre CR., Leydon, J. & Biggs, B-A. (2006). 'Chronic Strongyloides stercoralis infection in Laotian immigrants and refugees 7-20 years after resettlement in Australia'. Epidemiology and Infection, 128(3), 439-444.
84. Kogulan, P. & Lucey, D. (2005). Schistosomiasis. eMedicine. Last updated October , 2011. Retrieved from: < http://emedicine.medscape.com/article/228392-overview >.
85. Therapeutic Guidelines (2010). Therapeutic Guidelines: Antibiotic version 14. Accessible at: < www.tg.org.au/?sectionid=41 >.
86. Biggs, B-A., Durrheim, D., McCarthy, Page, W. & Speare, R. (2003). Recommendations from the Second National Workshop on Strongyloidiasis. Brisbane: 25-26 July. Retrieved from: < http://www.jcu.edu.au/school/phtm/PHTM/ss/2rec.htm >.
87. US Centers for Disease Control and Prevention. (2007). Refugee Health Guidelines: Intestinal Parasites Overseas Recommendations: Recommendations for Overseas Presumptive Treatment of Intestinal Parasites for Refugees Destined for the United States. CDC online: < www.cdc.gov/immigrantrefugeehealth/pdf/intestinal-parasites-overseas.pdf >.
88. Biggs, B-A., Caruana, S., Mihrshahi.S., Jolley, D., Leydon, J., Chea, L & Nuon, S. (2009). 'Management of Chronic Strongyloidiasis in Immigrants and Refugees: Is Serologic Testing Useful?'. American Journal of Tropical Medicine and Hygeine. 80 (5): 788-791.
89. Venereology Society of Victoria Inc. (2008). National management guidelines for sexually transmissible infections (7th ed.). Sexual Health Society of Victoria. Retrieved from: < http://www.mshc.org.au/Portals/6/NMGFSTI.pdf >.
90. WHO. (2001). Global Prevalence and Incidence of Selected Curable Sexually Transmitted Infections: Overview and Estimates. Geneva: WHO. Retrieved from: < www.who.int/docstore/hiv/GRSTI/who_hiv_aids_2001.02.pdf >.
91. Talley, NJ & Elsevier, CM. (2006). Clinical Gastroenterology (2nd. edn). Churchill Livingston, London.
92. ARHIG correspondence Jan 8th 2007, Dr. Sarah Cherian Telethon research Fellow (Refugee Health), Princess Margaret Hospital for Children, Perth
93. Talley, NJ. & Elsevier, CM. (2006). Clinical Gastroenterology (2nd. edn), Churchill Livingston, London.
94. WHO (2011). Fact sheets: chronic disease. Geneva: WHO. Retrieved from: < http://www.who.int/topics/chronic_diseases/factsheets/en/index.html >.

95. Dookeran, NM., Battaglia, T., Cochran, J. & Geltman, PL. (2010). 'Chronic Disease and Its Risk Factors Among Refugees and Asylees in Massachusetts, 2001-2005'. Diseases Journal MMWR, 2010, May, 7(3). Centers for Disease Control and Prevention United States Department of National Center for Chronic Disease Health and Human Services Prevention and Health.
96. WHO. (2011). Fact sheet number 317: Cardiovascular diseases. September. Geneva: WHO. Retrieved from: < www.who.int/mediacentre/factsheets/fs317/en/index.html >.
97. WHO. (2011). Fact sheet number 312: Diabetes. August. Geneva: WHO. Retrieved from: < www.who.int/mediacentre/factsheets/fs312/en/index.html >.
98. Vesti, P. & Kastrup, M. (1992). 'Psychotherapy with torture survivors' in Basoglu, M (ed.) Torture and its consequences: current treatment approaches. New York: Cambridge University Press. 348-362.
99. Danneskiold-Samsoe, B., Bartels, EM. & Genefke, I. (2007). 'Treatment of torture victims – a longitudinal clinical study'. Torture, 17(1), 11-17.
100. Hodges, PW. & Richardson, CA. (1996). 'Inefficient Muscular Stablization of the Lumbar Spine Associated With Low Back Pain: A Motor Control Evaluation of Tranversus Abdomins'. Spine, November, 21(22), 2640-2650.
101. Moseley, GL. (2004). 'Graded motor imagery is effective for long standing complex regional pain syndrome'. Pain, 108, 192-198.
102. Wand, BM., Parkitny, L., O'Connell, NE., Luomajoki, H., McAuley, J., Thacker, M. & Moseley, GL. (2011). 'Cortical changes with chronic low back pain: Current state of the art and implications for clinical practice'. Manual Therapy. 16(1):154-20.
103. Moseley, GL. (2003). 'A pain neuromatrix approach to patients with chronic pain'. Manual Therapy. 8(3), 130-140.
104. Clarke, CL., Ryan, CG., & Martin, DJ. (2011). 'Pain neurophysiology education for the management of individuals with chronic low back pain: A systematic review and meta-analysis'. Manual Therapy. 16(6):544-549.
105. Hough, A. (1992). 'Physiotherapy for Survivors of Torture'. Physiotherapy, 78(5), 323-328.
106. Kerewsky, HB. (1985). 'Trust, talk and touch in Balkan folk healing'. Social Science and Medicine, 21(3), 319-325.
107. Skylv, G. (1993). 'Falanga: diagnosis and treatment of late sequelae'. Torture 3, 11–15.
108. Minas, IH. (1995). Culture and Recovery from Traumatic Injury. Paper presented at the Innovations in Trauma Rehabilitation Conference Melbourne, 12-14 November, 1-9.
109. Bates E & Linder-Pelz S. (1987). Health Care Issues. New South Wales: Allen & Unwin.

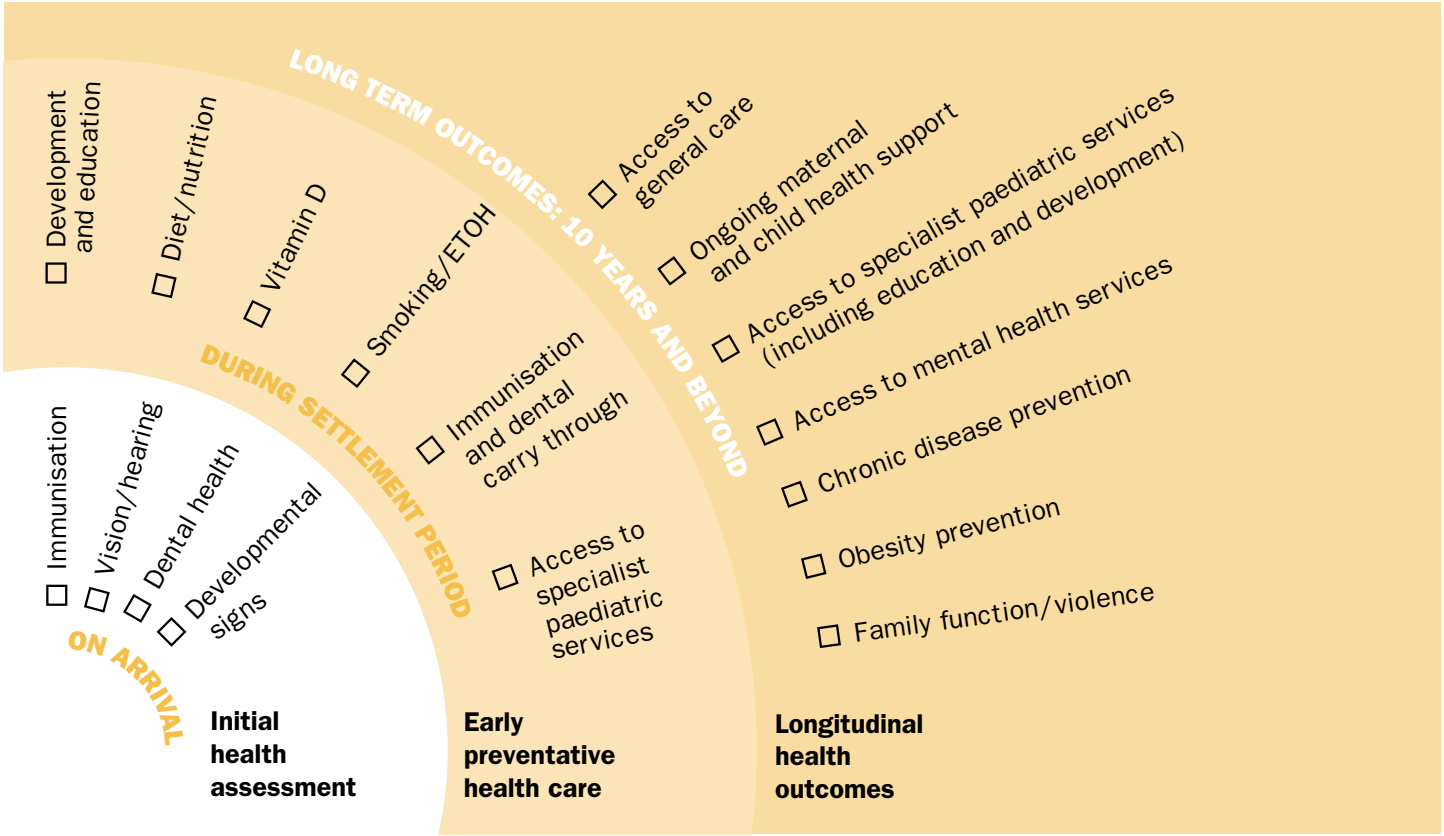
Section 5:
Child and adolescent health





FIGURE 5.1 Child health model for refugee health in Australia — optimal health care outcomes in the ten years following arrival

This longitudinal health outcomes diagram shows the trajectory for supporting children and adolescents of refugee background to transition to mainstream health services.



As shown in Figure 5.1, initial health assessment and care that addresses immediate health concerns is also a starting point to introduce longer term preventative health care, for example catch-up immunisation and dental referral. This section provides information on improving the immediate and long term health of children and adolescents of refugee background.

There are various definitions used for children, adolescents, youth and young people. Usually 'children' refers to those aged 0–9 years, 'adolescent' to those aged 10–19 years, 'youth' to those aged 15–24 years and 'young people' to those aged 10–24 years. The terms adolescent and young people are often used interchangeably. This Section is relevant for children and adolescents up to 18 years of age.

Humanitarian arrivals include a high proportion of children and adolescents. In 2011 nearly half the total humanitarian intake (49%) was aged <25 years, and the proportion was higher for people arriving under the offshore program (57% aged <25 years; 43% aged <18 years).[1] Families are often large, and there may be many children within a family group. Some refugee children and adolescents arrive as unaccompanied humanitarian minors, others arrive under alternative visas (e.g. orphan relative) and some arrived as asylum seekers who may subsequently be granted a permanent Australian visa.

Health and settlement services need to cater for the high proportion of children and adolescents and be aware of issues affecting this group.

Specific considerations include:

- Children 11 years of age and younger undergo only a limited pre-arrival health assessment screening (compared to adolescents and adults).
- The burden of disease or risk of disease complications may be higher in children and adolescents compared to other age groups.
- Screening tests may have lower sensitivity or may not be validated in younger age groups, and the interpretation of test results may vary with age.
- Paediatric pathology specimen collection should be used to reduce the amount of blood drawn for screening tests.
- Medication dosing varies with age, and medications may not be licensed for use in children.
- Immunisation catch-up varies with age.
- Children and adolescents may have an incorrect date of birth recorded on their migration paperwork; this is important to consider when assessing growth, development or learning.
- Children and adolescents typically learn new languages faster than their parents, which has implications for health care consultation and adjusting to life in Australia.
- Prior schooling may have been limited or disrupted, with implications for education placement in Australia.
- Mental health problems may present differently in children.
- Family structures and parenting roles may change with migration, affecting settlement.

Pre-arrival health screening

Any permanent entrant to Australia (including humanitarian entrants) must have a visa health assessment (VHA). This includes:[2] a physical examination, urine ward test (age <5 years), CXR (age <11 years), and HIV serology (age <15 years). There are no other routine screening tests, although unaccompanied minors and pregnant women undergo screening for hepatitis B, and applicants aged >15 years who have resided in a refugee camp are screened for syphilis infection. In practice, this means most children have extremely limited health screening offshore.

Humanitarian entrants may have additional offshore departure health check (DHC) (formerly known as the pre-departure medical screening or PDMS).[3]

The DHC includes a physical examination, malaria screening, immunisation against measles, mumps and rub ella (up to 54 years) and some treatment for parasites or infections. See Section 6 > 72 hour departure health check (p.231) for more information.

It is important for clinicians to be aware of the pre-arrival health screening process, as it has implications for post-arrival health care:

- Mantoux tests (screening for tuberculosis exposure) should not be performed within 1 month of a live virus vaccine (e.g. MMR vaccine given pre-arrival).
- Albendazole may result in false negative serology for Strongyloides infection.
- Refugees from the same source country may have different patterns of offshore health screening depending on their migration pathway.

Post-arrival health assessment

Refugee children and adolescents will have typical health problems and, in addition, may have health issues specific to their country of origin and refugee experience. A health assessment is recommended within 1 month of arrival,[4] or expediently if there is any clinical indication or Health Alert (see Section 6 > Health Alerts, p.233). Families (and adolescents individually) need to understand the importance and implications of health screening and give informed consent. This means explaining all tests, the conditions being screened, the meaning of a positive test and the next step in management.

Assessment of newly arrived refugee children and adolescents should focus on:

- parent (or self-identified) concerns
- excluding acute illness
- immunisation status and catch-up
- tuberculosis screening
- other infections, including parasites, malaria and hepatitis
- nutritional status and growth
- dental issues
- concerns about development, vision and hearing
- mental health issues
- previous severe or chronic childhood illness or physical trauma
- confirming the reported birth date
- issues arising during resettlement in Australia.

Suggested initial screening investigations[4, 5, 6]

- Full blood examination (FBE) and film
- Ferritin
- Vitamin A
- Vitamin D, calcium, phosphate, alkaline phosphatase (ALP)
- Malaria screen (thick and thin films and rapid diagnostic test)
- Hepatitis B serology (surface antigen (HBsAg), surface antibody (HBsAb) and core antibody (HBcAb))
- Hepatitis C serology (hepatitis C virus (HCV) antibodies)
- Schistosoma serology
- Strongyloides serology
- Faecal specimen (ideally fixed to improve detection of protozoa)
- Mantoux test (interferon gamma release assays (IGRA) are an alternative in those aged ≥14 years)
- STI screen (Neisseria gonorrhoea and Chlamydia trachomatis urine nucleic acid detection; syphilis serology) in sexually active adolescents, or if there is a history of sexual violence. Consider syphilis screening in all children to exclude congenital infection, children should be screened for syphilis if their mother has positive serology)
- HIV screening*

*The prevalence of HIV in recently arrived refugee children and adolescents in Australia is very low. HIV screening is recommended for all refugees in the ASID (2009) Diagnosis, management and prevention of infections in recently arrived refugees guidelines: www.asid.net.au/downloads/RefugeeGuidelines.pdf.

Overall there is likely to be limited benefit and considerable extra costs in terms of counselling and stress if this is included routinely in the initial screening. Testing should be completed in sexually active adolescents, if there is a history of sexual violence, where parents are deceased, missing or known to be HIV positive, or where there are clinical symptoms or signs.

Some groups may need additional screening investigations based on prevalence data from their country of origin or conditions prior to departure. There are reports of low B12/folate in Australian arrivals from Afghanistan and Sri Lanka, diabetes in Bhutanese populations, and high blood lead levels are reported in African[7, 8] South Asian[9, 10] and Burmese[11, 12] refugee children (see Haematology issues, p.198).

Additional (specialist) assessment are required in children and adolescents who:

- are unwell or have a fever (this requires urgent exclusion of malaria and other severe infection)
- are malnourished
- have clinical rickets
- have developmental issues
- have other localising symptoms/signs.

Key points in clinical assessment

Understanding the family history and migration pathway, together with language transitions, is important in appreciating the child and families experiences' and the effects of these on health and development.

It is important to take a background medical history; keeping in mind that there are additional considerations for refugee children and adolescents. Access to antenatal and perinatal care and child health screening (neonatal, vision, and hearing) may have been limited or non-existent. Prior access to health care, dental care and education varies widely. It is helpful to ask specifically about chronic diarrhoea, malnutrition in infancy, hospital admissions overseas, episodes of malaria, coma and physical trauma, as it is surprising how often these issues are not revealed initially.

Although it is standard of care to see adolescent patients alone for at least part of a consultation, this may not be feasible initially. Sexual history and counselling around some screening tests may need to be deferred until later visits. Serum can usually be taken with initial blood tests and held for testing at a later date (at the time of writing [March 2012] serum can be held for up to 5 weeks in community-based pathology services if requested).

Key points in history and examination related to post-arrival screening investigations are shown in Table 5.1.

TABLE 5.1 Key points in history and examination related to post-arrival screening investigations

History

- Fever (malaria, tuberculosis, other infections)
- Night sweats, malaise, weight loss, poor growth, chronic cough, contact/family history, health undertakings (tuberculosis)
- Low-grade bony and muscular pain, pain with exercise, dairy intake, symptoms of low calcium (muscle cramps), access to outside spaces and time spent outside, skin colour, covering (vitamin D)
- Tiredness, diet (excessive milk, weaning, solids, meat), food access, family history, blood loss (anaemia, iron deficiency)
- Jaundice, right upper quadrant pain, malaise (hepatitis)
- Family history, transfusion, shared needles (hepatitis, HIV)
- Abdominal pain, diarrhoea, blood PR, macroscopic worms, haematuria, rashes, skin nodules (parasites)
- BCG status, history of chickenpox, immunisation documentation and PDMS (immunisation status)
- Pregnancy, genital pain, discharge, ulcers, lumps and contact history (STI screening)

Examination

- A thorough physical examination of all systems is required.
- Growth parameters
- Nutritional status
- BCG scar
- Pallor (anaemia, haemoglobinopathies)
- Oral health (dentition, periodontal disease)
- ENT (chronic middle ear disease)
- Goitre (unscreened thyroid disease)
- Features of rickets (swelling of wrists/ankles, deformity (which reflects the age/growth of child when low vitamin D occurred), delayed dentition, late closure anterior fontanel, bossing
- Skin, hair, nails (dermatophytes)
- Respiratory exam/lymph nodes (tuberculosis)
- Abdominal exam – epigastric tenderness (Helicobacter pylori), hepatosplenomegaly (malaria, Schistosoma, HIV)
- Conditions that would usually be assessed during childhood and may have been missed (e.g. cardiac murmurs, inguinal herniae, undescended testes)
- Culturally specific findings (e.g. uvulectomy, teeth removal, scarification)

Differential diagnoses for common presentations in children and adolescents are shown in Table 5.2. For differential diagnosis in adults see Section 6 > Table 6.2.

TABLE 5.2 Differential diagnoses for common presentations

Presentation	Common causes	Additional considerations in refugee children *More likely shortly after arrival
Fever	Common viral infections Common bacterial infections (check for localising features, etc.)	Malaria* Dengue and other arboviral infections* Typhoid* Dysentery* **Tuberculosis** any site, especially if prolonged Dental disease (often missed)
Respiratory symptoms	Consider the usual causes of respiratory symptoms relevant to the age group, such as viral respiratory tract infection, pneumonia, asthma, bronchiolitis and croup.	**Whooping cough** (pertussis) vaccination may not have been available in country of origin. **Tuberculosis** (TB) – consider in children with cough >2 weeks. **Sickle cell disease** may present with acute chest syndrome. **Parasite** infections may (very rarely) cause wheeze/respiratory symptoms.
Abdominal pain	Consider the usual causes such as acute infection, constipation, surgical or gynaecological causes.	**Parasite infection** Helicobacter pylori **gastritis** – epigastric pain, early satiety, anorexia, nausea/vomiting, family history **Hepatitis**
Diarrhoea	Consider the usual viral and bacterial gastroenteritis.	**Bacillary*** and **amoebic dysentery** are common in the developing world. Parasitic infections are common. **Lactose intolerance** may be more common in some ethnic groups, it is more common in older children/adults.
Rashes	Eczema Dermatophyte (tinea) infections	Strongyloides **infection** may cause an intermittent urticarial rash lasting a few days (larva currens). This may be located anywhere but is most typically on the buttocks/perianal region. Skin nodules or a depigmented rash on the lower shins suggest **parasite infections**, specialist consultation is required.

TABLE 5.2 Differential diagnoses for common presentations continued

Presentation	Common causes	Additional considerations in refugee children *More likely shortly after arrival
Continence issues	Typical nocturnal or diurnal enuresis, bladder irritability	**Chronic urinary tract infection** may not have been detected/treated. Consider **mental health issues** as a cause of secondary enuresis. Consider **female genital mutilation (FGM)** as an additional possibility/contributor in girls (seek advice on how to broach this).
Musculoskeletal pain	Low vitamin D is an extremely common cause in refugee children and adolescents with risk factors.	
Fussy eating	Behavioural issues Excess milk intake	**Food insecurity** (not being able to afford/access adequate food) is well documented in refugee families after settlement. H. pylori **gastritis** is a common cause of poor appetite and fussy eating. Other gastrointestinal infections. **Dental disease** – pain with chewing may restrict food intake.

Immunisation

Vaccine preventable diseases are endemic and/or epidemic in countries of origin, and disruptions to health care may affect vaccine quality and access to immunisation. Most refugees do not have written documentation of immunisation, although, if present, written records are considered reliable evidence of vaccination status. Check for the presence of a BCG scar (deltoid, forearm, scapula, both sides and may be elsewhere) and a natural history of varicella (chickenpox).

Immunity to rubella should be checked in women of child-bearing age. Hepatitis B serology is part of post-arrival screening. Otherwise, routine serologic testing for immunity to vaccine preventable diseases is not recommended;[4] there is no significant cost benefit; it requires additional blood sampling, and combination vaccines mean the same vaccine will be required if there is inadequate immunity to any of the vaccine components. Specific information on catch-up vaccination is available in the Australian Immunisation Handbook (2008)[13]: immunise.health.gov.au.

KEY POINTS

Key points in immunisation catch-up

- No-one arriving as a refugee will be vaccinated and up to date according to the Australian immunisation schedule, due to differences in country of origin schedules.
- People of a refugee background should be vaccinated so they are up to date according to the Australian immunisation schedule, equivalent to an Australian-born person of the same age.
- Provide a written record and a clear plan for ongoing immunisations.
- Vaccination information for children <7 years should be entered into the Australian Childhood Information Register (ACIR).
- Measles, mumps, rubella (MMR) vaccine, and varicella zoster virus (VZV) vaccine are contraindicated during pregnancy and should not be given for 28 days before pregnancy.[13]
- If live viral vaccines (MMR/VZV) are not given simultaneously, they should be at least 4 weeks apart[13] (consider MMR/and yellow fever (YF) given as part of PDMS).
- For most vaccines there are no adverse events associated with additional doses in immune individuals. Extra doses of diphtheria–tetanus-containing vaccines and pneumococcal polysaccharide vaccines may be associated with increased local reactions. [13]
- A Mantoux test can be performed the same day as live viral vaccines; otherwise it should be deferred at least one month[13] (consider MMR/YF given as part of PDMS).
- Post-vaccination serology is recommended for household or sexual contacts of hepatitis B carriers (4–8 weeks after completing the primary course). [13]
- Consider medical conditions that require extra vaccine protection, such as anatomical/functional asplenia, haemoglobinopathies and HIV infection.
- Remind families to plan early for travel immunisations (many families travel and may be at increased risk when visiting friends and relatives in their country of origin).
- Translated immunisation information sheets are available from the Victorian Department of Health: health.vic.gov.au/immunisation/factsheets/language.htm.

See Table 5.3 (pp.189–191) for dosing, minimum dosing intervals and practice points.

TABLE 5.3 Immunisation catch-up table: dosing, minimum dosing intervals and practice points

Vaccine type	Age and number of doses	Route and dose	Min. dosing interval (months)	Notes
Diphtheria tetanus pertussis (DT containing)	<8 years, 4 doses DTPa	IM 0.5 ml	1, 1*, 6**	3 doses for primary series then **4th dose at 3½ to 4 years of age or 6 months after primary course. A hexavalent vaccine is available in all jurisdictions (states) combining DTPa with IPV/Hib/Hep B). *If using the hexavalent vaccine containing hepatitis B, dosing interval changes (2 months between doses 2 and 3).
	≥8 years 3 doses (dTpa, ADT, ADT)	IM 0.5 ml	1, 1	Insufficient data on 3 doses of dTpa, therefore recommend dTpa, ADT, ADT, then 10 year and 20 year booster dTpa. A single dose of dTpa is funded age 15–17 years.
Measles, mumps, rubella (MMR)	<8 years, 2 doses	IM or SC 0.5 ml	1	2nd dose due at 3½ to 4 years if <3½ years at first dose.
	≥8years (born >1966), 2 doses	IM or SC 0.5 ml	1	
Inactivated poliomyelitis vaccine (IPV)	Any, 3 doses*	Varies** 0.5 ml	1,1	*4th dose at 3½ to 4 years if <3½ years for primary course. Different combination vaccines available, combined with DTPa/dTpa/HiB/Hep B. **IPV in combination vaccines administered IM, IPV alone administered SC.
Hepatitis B	<11 years, 3 doses	IM 0.5 ml	1,2	Combination vaccines are available.
	11–15 years, 2 doses (adult formulation)	IM 1 ml	4	Alternate regimen is 3 doses of paediatric formulation (0.5 ml) as above.
	≥16 years, 3 doses*	IM Varies	1,2	*For age 16–19 years give 3 doses of paediatric formulation (0.5 ml), >20 years give 3 doses of adult formulation (1 ml).
Meningococcal C conjugate vaccine (MenCCV)	<8 years* 1 dose	IM 0.5 ml	–	*Normally given at age 12 months. Disease has bimodal peaks in incidence of <5 years and 15–24 years, catch-up previously funded to 19 years.

TABLE 5.3 Immunisation catch-up table: dosing, minimum dosing intervals and practice points continued

Vaccine type	Age and number of doses	Route and dose	Min. dosing interval (months)	Notes
Haemophilus influenza type b (Hib)	3–11 months, 2 or 3 doses, then booster* 12–14 months, 1 dose then booster* 15–59 months, 1 dose	IM 0.5 ml	1 or 2* varies*	Not required over 5 years of age. *Refer to Australian Immunisation Handbook for catch-up schedule in younger children – different vaccines require different catch-up schedules with different dosing intervals.
13-valent pneumococcal conjugate vaccine (13vPCV)	2–6 months, 3 doses 7–17 months, 2 doses 18–23 months, 1 dose	IM 0.5 ml	1,1 1 or 2* –	Required in children <2 years of age. The vaccine is funded if born after 1/1/2004. *Dosing interval is 1 month for 7–11 months age or 2 months for 12–17 months age. Children aged 12–23 months who have had 2 previous doses of 7vPCV should have a supplementary dose of 13vPCV (2 months after last 7vPCV).14 People with medical risk factors require extra doses of 13vPCV and 23vPPV (minimum 8 weeks apart).
Varicella vaccine (VV)	18 months – 13 years, 1 dose ≥14 years, negative serology, 2 doses	SC 0.5 ml	– 1	Funded if born after 1/5/2004 (at 18 months) or between 10–13 years if no history clinical varicella. VV is recommended in non-immune adolescents ≥14 years and adults (no clinical history and negative serology). People ≥14 years with a reliable history of varicella should be considered immune; check serology if no history of varicella.
Human papilloma virus (HPV)	12-13 years (females), 3 doses	IM 0.5 ml	1, 3	Complete doses within 12 months. Catch-up previously funded to 26 years, licensed for use in those aged 9–45 years.
Rotavirus	<6 months, 2 or 3 doses*	Oral 1 or 2 ml*	1	Not usually given as catch-up due to strict age restrictions. Dosing depends on vaccine type: • Rotarix (1ml): 2 doses at 2 and 4 months of age, 1st dose must be given <15 weeks of age, 2nd dose must be given <25 weeks of age. • Rotateq (2ml): 3 doses at 2, 4 and 6 months of age, 1st dose must be given <13 weeks of age, 3rd dose must be given <33 weeks of age.

TABLE 5.3 Immunisation catch-up table: dosing, minimum dosing intervals and practice points continued

Vaccine type	Age and number of doses	Route and dose	Min. dosing interval (months)	Notes
Bacillus calmette guerin (BCG)	<16 years,* 1 dose	ID Varies**	–	*Recommended in: • Children <5 years in households with immigrants/unscreened visitors from high prevalence countries15 • Children <5 years travelling to high prevalence area for >3 months[13] • Neonates with family history leprosy.[13] Consider in:[15] • Exposure to active pulmonary TB where isoniazid preventive therapy not possible, or after completion of isoniazid preventive therapy • Travel to high prevalence area >6 weeks if aged <5 yrs, >3 months aged >5 years Only given if no record/scar, no immunosuppression, no evidence TB infection (latent or active) and no other contraindications (see Australian Immunisation Handbook). **Dose varies with age (0.05 ml age <12 months, 0.1 ml age ≥ 12 months).

IM = Intramuscular, SC = Subcutaneous, ID = Intradermal.

This has been compiled from the Australian Immunisation Handbook (2008): immunise.health.gov.au.

An online version of this table is available from the Royal Children's Hospital (Victoria) Immigrant Health Service webpage: www.wch.org.au/immigranthealth/resources.cfm?doc_id=10813.

Nutritional issues

Nutritional issues are common. Fussy eating and concerns about weight gain (too little or too much) may be a family priority. These are common paediatric concerns, and are not specific to refugee families. Specific issues include low weight or height for age, vitamin D deficiency, other vitamin deficiencies, iron deficiency and anaemia. Increasingly, local clinicians are noting overweight/obesity as a health issue in the years after settlement.

Several studies suggest the prevalence of overweight/obesity is low in recently arrived refugee children and adolescents.[16, 17] However, immigrant cohorts are observed to have increased prevalence of overweight/obesity in the years after settlement[18] and subsequent generations.[19, 20] The early settlement period represents a window for health promotion around nutrition, and dietician referral may be appropriate.

KEY POINTS

Key considerations in the assessment of nutritional status and growth

- It is important to take a good dietary (and general) history and ascertain access to and quantity/quality of food overseas and after settlement. Food insecurity after resettlement is well reported in refugee communities, including in Australia.[21, 22]
- Fussy eating (+/- growth issues) is often due to high caloric intake in the form of drinks/juices at the expense of solids/mealtimes. It may also be due to a mismatch between the food the child is used to, and food offered at childcare/school.
- An early severe/prolonged nutritional insult or chronic disease during infancy will affect long-term growth and may affect final height ('stunting'). This history is usually easily elicited.
- Consider organic disease early in refugee children with poor growth or reduced appetite, including gastrointestinal infections (*Helicobacter pylori* gastritis, *Giardia intestinalis*, other parasites), other infections (including TB), low vitamin D/rickets and dental disease (leading to difficulty chewing). Iron deficiency may affect appetite and compound poor intake. Mental health issues may also be a cause of poor intake/growth.

- Consider family patterns of growth/puberty, remembering parents may have also been malnourished.
- Clarify the correct age/birth date, chart growth parameters on percentile charts (weight/height/BMI) and check pubertal status. Measure parent height where possible.
- In children with poor nutrition:
  - Assess for macronutrient deficiency (fat/protein/carbohydrate) by checking growth (as above), oedema, muscle bulk, subcutaneous fat stores and mid upper arm circumference
  - Assess for micronutrient deficiency (vitamin/trace element/mineral) by checking pallor, xerophthalmia, cheilitis, glossitis, gum disease, goitre, rash, rickets, neuropathy, hair and nail changes
  - Assess for organic medical contributors.
- In children who are overweight (uncommon on initial post-arrival screening):
  - Assess for complications/associations – girth, striae, hypertension, signs of hyperlipidaemia, acanthosis, early puberty, joint problems, obstructive sleep symptoms, pulmonary hypertension, syndromal features.

Post-natal growth is most rapid during early infancy; then slows by the primary school years, picking up again at puberty. Linear growth is similar in children aged <5 years worldwide,[23] although growth must be considered in the context of parent height, ethnicity (Australian growth charts are based on American data)[24] and pubertal status. Children and adolescents may have different growth parameters to their Australian-born peers and still have normal growth. It is important to remember that 23% of Australian children and adolescents are overweight or obese.[25]

Most common causes of poor growth in refugee children and adolescents are elicited with a careful history and the initial refugee health screening investigations. Once the initial screen has been completed and treatment initiated as necessary, a period of monitoring growth is often appropriate.

The principles of healthy eating are universal and should be discussed with families. Breastfeeding should be promoted. Encourage introduction of solids at 4–6 months of age, introduction of meat before 12 months and an appropriate diet containing vegetables, legumes, fruit, cereals, meat and dairy. Milk should be limited to <600 ml daily after 12 months; in children with lactose intolerance, regular yoghurt and cheese are appropriate sources of calcium. Adequate calcium intake is essential for all children but has additional implications in groups at risk for low vitamin D. Home-cooked food and maintaining families' cultural food preferences is usually healthier and more economical.

Consider referral to a dietician or extra help from the Maternal and Child Health Service. See Section 11 (p.323).

Vitamin A

Vitamin A is required for vision, immune function, growth and maintenance of epithelial cells. Vitamin A is contained in yellow/orange fruits and vegetables, and also butter, eggs, cheese and liver, although the content is reduced by cooking. Infants rely on their own stores and breast milk for supply. The World Health Organization (WHO) recommends vitamin A supplementation in infants, children and post-partum women in countries where vitamin A deficiency is a problem.

Vitamin A deficiency has been found in refugee children and adolescents after settlement; local studies have found low vitamin A in 20% of East African[16] children and adolescents and 3% of Karen refugee children.[26] It is more likely in children with restricted food access overseas, especially if they did not receive supplements. It is extremely unlikely in healthy children settled in Australia with access to a broad range of food, and screening is not recommended outside the initial settlement period. Vitamin A is light sensitive, and blood samples for testing must be protected from light or the test result will be (falsely) low.

One unit of vitamin A = 0.3 microgram (mcg) retinol. 50,000 IU vitamin A gel capsules are available (non-prescription).

Low vitamin A should be treated as follows (Table 5.4):

TABLE 5.4 Oral treatment for vitamin A deficiency

Vitamin A level	Age	Vitamin A dose	Follow-up
0.35–0.7 mmol/L (or low for age)	<6 months	50,000 IU oral stat	Repeat dose at 6 months if risk factors persist.
	6–12 months	100,000 IU oral stat	
	>12 months	200,000 IU oral stat	
<0.35 mmol/L (or eye signs)	<6 months	50,000 IU oral daily for 2 days	Repeat dose at 2–4 weeks and follow-up with repeat levels.
	6–12 months	100,000 IU oral daily for 2 days	
	>12 months	200,000 IU oral daily for 2 days	

Promote breastfeeding (in infants), and foods containing vitamin A in the diet. Further information is available from the Royal Children's Hospital (Victoria) Immigrant Health Service: rch.org.au/immigranthealth/resources.cfm?doc_id=10862.

Vitamin D

Vitamin D is essential for bone and muscle health, and there is evidence it is important in other aspects of health. Low vitamin D causes increased bone turnover and inadequate bone mineralisation, with the endpoints of rickets in children and osteomalacia in adults. Vitamin D deficiency may be asymptomatic or be associated with non-specific bone pain, muscle pain, poor exercise tolerance and fatigue. Features of rickets include leg deformity, swollen wrists/ankles, rachitic rosary and delayed dentition/anterior fontanel closure. Very low vitamin D levels may cause symptomatic hypocalcaemia (stridor, tetany, seizures); this is more common in infants <6 months. Definitions of vitamin D status are shown in Table 5.5.

TABLE 5.5 Definitions of vitamin D status

Severe deficiency	<12.5 nmol/L
Moderate deficiency	12.5–29 nmol/L
Mild deficiency	30–49 nmol/L
Sufficient	≥50 nmol/L
Elevated	>250 nmol/L

Most vitamin D is made in the skin through the action of the ultraviolet B (UVB) wavelength of sunlight. Neonatal vitamin D levels reflect maternal stores (and are approximately 65% of maternal levels).[27] However, sunlight is the most important source of vitamin D from infancy onwards.

The amount of UVB available for skin synthesis of vitamin D varies with latitude, season, time of day, shade, and skin exposure. Window glass blocks UVB. In theory, sunscreen reduces skin synthesis of vitamin D.[28] However, normal use is not associated with low levels in adults[29] (no paediatric data are available). The skin pigment melanin protects against UV radiation, and people with naturally dark skin probably require 2 to 7 times as much sun exposure to make adequate vitamin D[29] compared to people with light skin. There may not be enough UVB for people with dark skin to maintain their vitamin D over the winter months in the southern states of Australia.

Diet is a generally a poor source of vitamin D in Australians,[30] and only accounts for around 10% of requirements. Vitamin D is only found naturally in only a few foods (e.g. fatty fish) although some milk is fortified and small amounts are added to margarine. Meat is not a source of vitamin D. Baby formula is fortified with vitamin D (360–520 IU/L). Breast milk, despite its other benefits, contains almost no vitamin D.[31] The revised United States (US) recommended daily allowances are shown in Table 5.6.

TABLE 5.6 Revised US recommended dietary allowances for calcium and vitamin D[32] (in the absence of sun exposure)

Age	Adequate intake (AI)	Estimated average requirement (EAR)	Recommended daily allowance (RDA)
<12 months	400 IU daily	–	–
1–18 years		400 IU daily	600 IU daily
19–70 years		400 IU daily	600 IU daily
>70 years		400 IU daily	800 IU daily
Pregnancy/ lactation		400 IU daily	600 IU daily

AI – used when no EAR or RDA available, based on observed/ experimental intakes.

EAR – reflects estimated median requirements.

RDA – meets or exceeds the requirements for 97.5% of the population.

Refugee communities may have multiple risk factors for low vitamin D; e.g. dark skin, little exposure to sunlight due to dress and limited time outside. Australian studies have found 61–100% in African refugees in Melbourne, Adelaide and Sydney have low vitamin D (<50 nmol/L)[16, 33, 34, 35, 36, 37] and Australian and New Zealand studies have found 60–80% of veiled and/or dark skinned women attending antenatal clinics have levels <25 nmol/L.[38, 39, 40] Rickets has re-emerged as a child health issue in Australia; notably almost all children in two large Australian case series had ethno-cultural risk factors (dark skin, maternal covering clothing).[41, 42]

Low vitamin D is also seen commonly in other refugee communities, especially those wearing who have little exposure to sunlight due to dress (often including Afghani, Iraqi), and has also been found in 33% of Karen refugees.[26]

GROUPS AT RISK OF LOW VITAMIN D

- People who do not expose their skin to sunlight or who spend most of their time indoors
- People with naturally dark skin
- People with conditions affecting vitamin D metabolism (malabsorption, obesity, liver/renal disease, medications including rifampicin)
- Babies born to women with low vitamin D
- Exclusively breastfed babies with other risk factors

KEY POINTS

Key points in screening and management of low vitamin D

- 25-hydroxy vitamin D (25(OH)D) is used to measure vitamin D stores.
- The recommended level for serum 25(OH)D is ≥50 nmol/L (at all ages and during pregnancy).
- Measure vitamin D, calcium, phosphate and ALP in all children and adolescents with risk factors. Also measure parathyroid hormone in those with low calcium intake, symptoms/signs or multiple risk factors.
- Children with hypocalcaemia or rickets need urgent specialist assessment and will require further investigations.
- If the initial vitamin D level is normal, repeat at the end of the first winter in Australia.
- Children and adolescents with low vitamin D should be treated to restore their levels to the normal range with either daily dosing or high-dose therapy. D3 is the only form currently available in supplements.
  - Age 1–18 years:
    1000–2000 IU daily for 3–6 months depending on levels,
    or
    150,000 IU single dose, and repeat at 6 weeks for those with levels <30 nmol/L.
- Ensure adequate calcium intake, children and adolescents may need calcium supplements if dietary intake is poor.
- Treatment should be paired with health education and advice about sun exposure/sun protection; encouraging outside play/activity. Children/young people with dark skin can tolerate intermittent sun exposure without sunscreen. Hats/sunglasses are still recommended.
- Follow-up bloods at 3 months (earlier in infants with moderate – severe deficiency).
- Children and adolescents with ongoing risk factors for low vitamin D require ongoing monitoring, with annual testing and a plan to maintain vitamin D and calcium status through behavioural change where possible, and supplementation where this is inadequate. Some children may require high-dose therapy more than once a year.
- Breastfed babies at risk of low vitamin D should be given 400 IU daily for at least the first 12 months of life.

RESOURCES

- For more detailed paediatric protocols including vitamin D dosing in infants and calcium requirements, see 'Low Vitamin D' on the Royal Children's Hospital Immigrant Health Service website: rch.org.au/immigranthealth/resources.cfm?doc_id=10782.
- For information on groups at risk of low vitamin D, the amount of sun exposure needed for different skin types in order to maintain stores of vitamin D and for information on screening and treatment, see the 'Low Vitamin D in Victoria: Key messages for doctors, nurses and allied health' document, available from the Victorian Department of Health website: www.health.vic.gov.au/chiefhealthofficer/publications/low_vitamin_d_med.htm.

Haematology issues

Australian data suggest the prevalence of anaemia is 10–30% in refugee children,[16, 26, 37, 43] with similar prevalence in children from Africa, Middle East or Asia. Iron deficiency affects a similar proportion,[16, 26, 37] and is associated with tiredness, irritability and adverse effects on cognitive development.[44]

Anaemia is usually multifactorial in refugee children and adolescents. Contributors include iron deficiency, malaria, and parasite infection/infestation. Iron deficiency is usually nutritional, but may be due to gastrointestinal loss or associated with Helicobacter pylori infection.

B12 and folate deficiency have been reported in refugees from Afghanistan and Sri Lanka in Australia, and should be considered in any refugee with restricted food access pre-arrival (lack of animal products associated with B12 deficiency; lack of fresh food associated with folate deficiency). Haemoglobinopathies are more common in African, Asian and Middle Eastern populations. This means many children will be carriers, with microcytosis, and sometimes, mild anaemia (actual disease is uncommon). Screening for carrier status is not routine for children, sickle cell disease/thalassaemia major/significant other haemoglobinopathy should be apparent based on clinical examination and FBE.

Elevated blood lead levels (>10 mcg/dL) are associated with cognitive impairment (>10 mcg/dL), anaemia (>25 mcg/dL) and central nervous system (CNS)/gastrointestinal symptoms (>60 mcg/dL).[45] Levels peak in children around the age of 2 years, then decrease. Elevated blood lead levels have been reported in up to 7–13% of African[7, 8] South Asian[9, 10] and Burmese[11, 12] refugee children, especially in those aged <6 years; although rarely to a level requiring chelation therapy (>45 mcg/dL). Testing for blood lead levels is recommended in recently arrived refugee children (aged 6 months—16 years) in the US,[45, 46] they are not currently part of initial refugee screening protocols in Australia, although this may change. Consider second-line screening in children with microcytic anaemia, and initially in children with pica, developmental issues or a history of exposure, including through traditional medicines. Both iron deficiency and inadequate calcium intake may potentiate lead absorption.[45]

Children and adolescents from Africa commonly have a neutrophil count below Australian reference ranges. In clinically well children and adolescents (including no fevers, gingivitis, or skin infections) this is usually a normal variant.

KEY POINTS

Key points in screening and management of haematology issues

- Routine screening tests are FBE film and ferritin.
  - Serum ferritin (an iron storage protein) provides a reasonably accurate estimate of iron stores in the absence of inflammatory disease.
  - Low iron stores may result in false negative results (lack of elevated HbA2) in haemoglobin electrophoresis in beta-thalassaemia carrier state (although screening for Haemoglobinopathies is not routine in refugee children and adolescents).
  - Also measure serum active B12 (holotranscobalamin) and red cell folate if clinically indicated, and measure serum lead in children with pica, development issues or a history suggesting exposure.
  - Serum active B12 measures the biologically available form of B12 and is a more accurate indicator of B12 status than total B12.
- Low iron stores may result in false negative results (lack of elevated HbA2) in haemoglobin electrophoresis in beta-thalassaemia carrier state.

- Iron deficiency should be treated using oral iron supplementation, giving a dose of elemental iron of 2–6 mg/kg/day for around 3 months (see examples in Table 5.7). Discuss side effects (gastric upset, constipation, dark stools) and safety/storage. Iron is extremely toxic in overdose.
- Low B12 needs urgent specialist consultation/review. The child will typically require further investigations to clarify dietary or metabolic causes of low B12 (urine methylmalonic acid/serum homocysteine) then treatment with intramuscular B12. Low B12 associated with any one of developmental delay/regression; seizures, or failure to thrive is an emergency and requires specialist haematology advice.
- Low folate should not be treated until low B12 has been excluded (and treated if present) to avoid precipitating sub-acute combined degeneration of the spinal cord.

TABLE 5.7 Oral iron supplementation

Product	Dose
Ferro-liquid™ (6 mg elemental iron/ml; 30 mg FeS04/ml))	0.3–1 ml/kg/d given in divided doses
Ferrogradumet™ (105 mg elemental iron/tablet; 325 mg FeS04/tablet)	1 tablet daily (or b.d. depending on weight)
Ferro-tab™ (65.7 mg elemental iron/tablet; 200 mg ferrous fumarate/tablet)	1 tablet 2–3 times daily
Fefol delayed release™ (87.4 mg elemental iron/tablet; 270 mg FeS04/tablet; also contains folic acid 300 mcg/tablet)	1 tablet daily

Tuberculosis screening

Tuberculosis (TB) screening and management for adults is covered in Section 4 > Tuberculosis (p.131). Also see state and territory guidelines, for example the Victorian TB guidelines: ideas.health.vic.gov.au/diseases/tuberculosis-management-guide.asp.

Tuberculosis is caused by infection with Mycobacterium tuberculosis (MTB). Approximately one third of the worlds' population is infected, although only 5–10% of people with infection develop TB disease. TB disease may be primary disease (occurring directly after initial infection) or reactivation disease (occurring after a latent period that may be many years).

TB screening requires a history, examination, and a TB screening test (tuberculin skin test (TST), e.g. Mantoux test, or interferon gamma release assay (IGRA)). A positive TB screening test result does not distinguish between TB infection or TB disease, and a negative TB screening test result does not exclude either LTBI or TB disease.

Latent TB infection (LTBI) refers to evidence of TB infection (i.e. positive screening test), without evidence of TB disease (based on history, examination, chest X-ray (CXR) and other investigations as clinically indicated). Clinically, this is an asymptomatic child or adolescent with a positive screening test and a normal CXR. In children and adolescents with LTBI the lifetime risk of developing TB disease is in the order of 10%, although it is higher in those aged <5 years; especially in those aged <2 years.

LTBI is common in refugee children and adolescents. Available Australian data suggest the prevalence of a positive TST (≥10 mm) in refugees from Africa, Europe and the Middle East is 25–55%.[36, 37, 47] TB disease has been found in 1.7–3.3% of refugee children/adolescents attending a refugee service in New South Wales.[36, 37]

KEY POINTS

Key points in the screening, presentation and diagnosis of TB in children and adolescents

- Children <11 years of age are not routinely screened for TB pre-migration (except for clinical examination).
- Primary TB is more common in children than in adolescents and adults, who are more likely to get reactivation disease.
- Following exposure, the risk of progression to TB disease is highest in young children (<5 years, especially <2 years); adolescents also have a relatively increased risk. The risk is higher in the first years after migration.
- Children are more likely to develop disseminated or non-pulmonary TB disease than adults; infants are particularly prone to miliary TB and TB meningitis.
- Children with pulmonary TB disease are rarely infectious due to their pattern of disease, low bacillary load and lack of coughing force.
- The Mantoux test (TST) is the preferred first-line screen in children <14 years, although it is less reliable in those aged <6 months. It can be used at all ages. See Mantoux tests – technical aspects and interpretation (p.203).
  - A false negative result may occur with very recent exposure, active disease, immunosuppression and within 4 weeks of live viral vaccines.
  - A false positive result may occur as a result of previous BCG immunisation (particularly if given after early infancy) or exposure to non-tuberculous mycobacteria.
- Interferon gamma release assays (IGRA) such as QFN-GIT® or T-SPOT-TB® are not suitable as first-line screening tests in children. Their performance has been queried in this age group; multiple studies have found a proportion of children have a negative IGRA but a positive TST. A positive IGRA test should be interpreted as infection with MTB (but does not distinguish between LTBI or TB disease), a negative IGRA does not exclude either LTBI or TB disease.
- Routine use of both TST and IGRA is not recommended.
- Children tend to swallow sputum rather than expectorate it, and it is more difficult to establish a microbiological diagnosis in pulmonary TB disease (usually confirmed in only 30–40%).
- Early morning gastric aspirates are used instead of sputum for microbial diagnosis in children.
- Children/young people with LTBI tolerate preventive therapy with isoniazid well, and have a lower rate of hepatic complications than older adults.

Mantoux tests – technical aspects and interpretation

Technical aspects

- Document presence/location of BCG scar
- Intradermal injection (26G/27G 10mm needle, bevel up) 5 tuberculin units (TU) purified protein derivative (PPD) (0.1 ml of 50 TU/ml solution)
- Given in the left forearm at the junction of the middle and upper thirds
- Read at 48–72 hours (up to 5 days); measure induration (not erythema) in the transverse axis
- Less reliable in children aged <6 months
- Do not administer within 4 weeks of live viral vaccines (MMR or VZV)
- Do not administer if past history of active TB (likely to cause large reaction) or previous large reaction to TST

interpretation

A positive result is:

- ≥5 mm in children/adolescents who are household contacts of an adult with active TB disease
- ≥10 mm in children/adolescents without a direct contact, who are from an endemic area.
- Although some authors suggest using a cut-off of 15 mm for a positive TST if the child or adolescent has had a BCG in the preceding 5 years, BCG is usually given at birth and the risk of progression to TB disease is greatest in children <5 years. Most experts would recommend preventive treatment to children aged <5 years with a TST of ≥10 mm and no evidence of active disease. It is therefore safest to ignore BCG immunisation when interpreting a TST.

KEY POINTS

Key points in screening and management of tuberculosis infection (LTBI/TB disease)

- Ask about BCG status, past history, contact history (including family history), pre-departure screening and health undertakings in the family, and symptoms:
  - fever, night sweats, malaise
  - weight loss or poor weight gain
  - cough, other respiratory symptoms
  - nodal or bony symptoms.

Often a contact history will emerge after initial screening results are positive; it is wise to repeat the entire history.

- Screen those aged <14 years using a TST, in those aged ≥14 years an IGRA is an alternative.
- All children and adolescents with suspected TB infection or TB disease need prompt specialist review.
- Children and adolescents who have household contact with someone with TB disease require prompt specialist review. This will usually be arranged through local TB services; but check to see this has occurred.
- All children and adolescents with a positive TST (or IGRA) need a CXR; films should be sent with the child for specialist review if completed in primary care.

- Children and adolescents with LTBI are offered preventive therapy; at the time of writing (early 2012) this is typically 6 months daily isoniazid therapy. This reduces the risk of developing active disease by 50–90%.
- In children and adolescents with TB disease, microbiological confirmation is sought. Standard treatment is 6 months of multi-agent therapy; longer durations are used for some forms of extrapulmonary or disseminated TB disease. Children and adolescents with TB disease should be tested for HIV and low vitamin D.
- Consider BCG immunisation in other children in the family if they have not previously received this vaccine (see Section 4 > Adult Health > Tuberculosis for more information).

Hepatitis B infection

Hepatitis B screening and management in adults is covered in Section 4 > Adult Health > Hepatitis B (p.136). Hepatitis B is a viral infection affecting the liver that is transmitted through exposure to infected body fluids (usually blood borne or sexual). Vertical (mother-to-child) and horizontal transmission are important in the epidemiology of childhood hepatitis B. Horizontal transmission is also important in household contacts of people with hepatitis B infection.

The clinical manifestations of hepatitis B virus (HBV) depend on age of acquisition, viral load and host immune response.

- Infants who acquire HBV do not usually have symptoms, but up to 90% will develop chronic infection.
- In children 1–5 years, 5–15% will have symptoms and 25–50% will develop chronic infection.
- In older children, adolescents and adults, 33–50% will have symptoms and 6–10% will develop chronic infection[48, 49]

Chronic HBV infection is associated with cirrhosis, liver failure and liver cancer; 15–40% of people with chronic HBV will develop serious complications.[50] In people with chronic infection only 0.5% will clear the infection yearly.[51]

Current humanitarian source countries all have intermediate (2–7%) or high (≥8%) prevalence of HBV infection. Recent studies in refugee cohorts in Australia suggest the prevalence of chronic hepatitis B infection is:

- 2–16% in people from Africa [33, 37, 43, 47, 52, 53, 54] (although it was 38% in a small cohort in Darwin)[55]
- 3–10% in people from South/South East Asia[26, 47, 54, 55]
- 0–2.5% in people from Afghanistan/Iraq.[47, 56]

While many refugees remain susceptible to hepatitis B transmission, Australian studies suggest the proportion of refugees who are not immune to hepatitis B is:

- 67–74% of African children and adolescents[43, 57]
- 40–43% of African adults[43, 58]
- 50% of Karen refugees.[26]

Initial hepatitis B screening tests include hepatitis B surface antigen (HBsAg), core antibody (HBcAb) and surface antibody (HBsAb or anti-HBs). HBsAb >10 IU/L indicates adequate immunity. Test interpretation is shown in Table 5.8.

TABLE 5.8 Hepatitis B test interpretation

Hepatitis B screening results	Interpretation
HBsAg + HBcAb + HBsAb –	HBV infection, either acute or chronic In acute infection HBcIgM will be positive, carrier state/chronic infection is defined by the presence of HBsAg for >6 months.
HBsAg – HBcAb + HBsAb +	HBV immunity due to exposure to HBV and resolved infection
HBsAg – HBcAb – HBsAb +	HBV immunity due to vaccination
HBsAg – HBcAb + HBsAb –	Isolated core antibody positive. May represent the window phase of acute hepatitis B (check liver function tests), a false positive result (more common in people from low prevalence areas), immunity after previous infection with waning HBsAb or chronic HBV infection.

KEY POINTS

Key points in screening and management of hepatitis B

- Ask about contact and household history, family history (liver disease/cancer), other risk factors (transfusion, dental work, needles, sexual history if appropriate) and health undertakings (which may sometimes be for HBV). Children and adolescents with chronic HBV are usually asymptomatic.
- Given the prevalence of HBV in refugee communities and household mobility in early settlement, assume household contact is the norm rather than the exception.
- Vaccination of non-immune (sAb ≤ 10 IU ml) people is a priority.
- In children and adolescents who are isolated cAb positive, a reasonable approach is to give a single dose of hepatitis B vaccination and repeat cAb/sAb and LFT 1 month after vaccination. If sAb still negative, complete a full course of HB vaccination, and repeat sAb 1 month after final dose; refer for specialist review if still negative.
- Children and adolescents who are HBsAg positive require specialist referral.
  - They need further assessment and tests to determine acute/chronic infection (cAb IgM and IgG); HBV replication status (liver function tests, HB e antigen (eAg), HB e antibody (eAb/anti-HBe) and HBV-DNA (viral load) and complications (FWTU (proteinuria), liver ultrasound, and AFP). Genotyping may be used in the future but is not routine at present. These tests are normally completed at specialist level.
  - Some children may require a liver biopsy and may be treated for HBV.

The following are important considerations at both specialist and the primary care level:

- Consideration of comorbidities: other viral hepatitis (hepatitis C virus (HCV) and hepatitis delta), HIV, schistosomiasis, other STI.
- Monitoring of LFTs with hepatotoxic medications (e.g. TB preventive therapy).
- Vaccination against hepatitis A if non-immune.

- Education and counselling, with plenty of opportunity for discussion over time. Advice on preventing transmission should include discussion on cleaning blood spills, not sharing toothbrushes/razors, vaccination of contacts and use of barrier contraception in adolescents. Adolescents should also be advised about limiting alcohol consumption. Families/adolescents should notify other doctors when starting new medications.
- Screening and vaccination of household/sexual contacts with post-vaccination serology (4–8 weeks after completing the primary course).[13]

The key challenge in management of children and adolescents with HBV is that they need lifelong monitoring and follow-up, with transition to adult services. This requires coordination between primary and specialist level care, and opportunistic surveillance (and often re-referral) over many years.

RESOURCES

- The Australasian Society for HIV Medicine (ASHM) and the Cancer Council of NWS have put together a downloadable resource designed to give primary care practitioners an overview of current hepatitis B knowledge in Australia. It is entitled 'B positive: all you wanted to know about hepatitis B' (2008) and is available from the ASHM website http://ashm.org.au/images/publications/monographs/b%20positive/b_positive-all_you_wanted_to_know.pdf
- For Hepatitis B screening and management protocols, see the Royal Children's Hospital Immigrant Health Service website: rch.org.au/immigranthealth/resources.cfm?doc_id=10812.
- Information for patients, in many patient languages is available from the Health Translations website. For Hep B information see: www.healthtranslations.vic.gov.au/bhcv2/bhcht.nsf/htsearchresults?open&st=b&v=1&tx=hepatitis_B&jn=.4253352&sl=&so=&sc=&sz=q=hepatitis%20B%7C%7C%7C%7Cbasic%7C.

Parasites

Pathogenic faecal parasites are common in refugee children and adolescents and are found in 16–39% on post-arrival health screening.[59] Giardia intestinalis is the most common pathogen identified, found in 11–19% of refugees from Africa and Asia.[59] Children typically have a higher prevalence of faecal parasites compared to adults.

Pathogenic faecal parasites are found in refugee cohorts from all areas, including Europe and the Middle East, as well as Africa and Asia. Symptoms include abdominal pain (which may be anywhere), constipation and diarrhoea. Macroscopically visible worms are likely to be tapeworms or ascarids. Faecal microscopy is recommended, especially if symptoms are present.[4] Fixed faecal specimens improve detection of protozoan parasites. Table 5.9 shows faecal parasites requiring treatment and those generally considered to be non-pathogenic.

TABLE 5.9 Pathogenic and non-pathogenic parasites

Pathogenic parasites requiring treatment	Non-pathogenic parasites (no treatment required)
• Entamoeba histolytica	• Entamoeba coli
• Ascaris lumbricoides	• Entamoeba hartmanii
• Giardia intestinalis	• Entamoeba gingivalis
• Ancylostoma or Necator (hookworm).	• Endolimax nana
• Strongyloides stercoralis (requires special culture techniques)	• Iodamoeba butschlii
• Schistosoma spp.	• Dientamoeba fragilis*
• Taenia solium or saginata (tapeworm).	• Blastocystis hominis*
• Trichuris trichiura (whip worm).	• Chilomastix mesnili
• Hymenolepis nana (dwarf tapeworm)	• Trichomonas hominis
	*Rarely implicated as a pathogen

Parasite infections may last for years and have sequelae for nutrition, growth and function. In general, treatment is usually short-course (often single-dose) and well tolerated. The ASID guidelines[4] recommend empiric anti-helminth therapy (albendazole) if not received as part of PDMS. However, it is important to remember this treats many, but not all, parasites, and specific therapy is needed for giardiasis, amoebiasis, schistosomiasis, strongyloidiasis, Taenia spp and Hymenolepis nana (dwarf tapeworm).

Schistosoma **infection** is endemic in Africa, but is also found in Asia and the Middle East. It is often called 'Bilharzia' in Africa, and families may know this name. Australian post-arrival screening data have found the prevalence of Schistosoma infection is 12–38% in African refugees[54, 55, 59] and 7% in Karen refugees.[26] It is important to detect and treat Schistosoma infection in children and adolescents to prevent end stage disease, which can occur many years later. Treatment is with praziquantel.

Strongyloides **infection** is also common in refugee cohorts, Australian post-arrival screening data have found the prevalence is 1–9% in African refugees[54, 55, 59] and 21% in Karen refugees.[26] Strongyloides infection has also been seen in refugees from Bosnia.

KEY POINTS

Key points in screening and management of Strongyloides infection

- Strongyoides infection can last for decades through a cycle of autoinfection.
- Positive serology indicates active infection (requiring treatment).
- In the setting of immunosuppression, Strongyloides can cause a hyperinfection syndrome that has a high case fatality (even with treatment). People from Strongyloides endemic areas should have repeat screening prior to starting immunosuppression (regardless of the duration since migration) if their Strongyloides status is unknown.
- Treatment is with ivermectin (≥5 years or weight >15 kg).
- Repeat serology 6 months after treatment (it should become negative, repeat treatment if remains positive).
- Albendazole for 3 days is an alternative treatment in children 2–5 years, although it is less effective (around 60%). Follow-up serology is required and subsequent treatment with ivermectin may be required.

Protocols including paediatric dosing for parasite infection are available from the Royal Children's Hospital (Victoria) Immigrant Health Service: rch.org.au/immigranthealth/resources.cfm?doc_id=10785.

Details on specific parasites are in Section 4 > Adult Health > Infectious diseases and parasites (p.128).

Malaria

Cerebral malaria and most severe malaria is caused by Plasmodium falciparum, with the highest burden of disease in young children before the development of adequate immunity. People living in endemic areas typically develop immunity during childhood and may be infected but asymptomatic. They are at increased risk of symptomatic infection after migration as their immunity wanes. The prevalence of malaria was 5–10% in Australian paediatric refugee cohorts from Africa[33, 37, 47, 52, 60] This has reduced since the introduction of pre-departure screeing practices.

Clinical malaria caused by Plasmodium falciparum will generally present within 6 weeks of resettlement, but may present later. It is rare beyond 3 months. Other malarial species may be detected many months after resettlement.

KEY POINTS

Key points in screening and management of malaria

- Malaria should be excluded urgently in any recently arrived febrile child or adolescent of refugee background (including those who have returned from recent travel to visit family overseas) with both blood film and rapid diagnostic test (RDT). Specify countries of origin and transit and recent treatment on pathology request forms. Multiple films are required if initial testing is negative and there is a high clinical suspicion of malaria.
- Detection of P. falciparum species on rapid diagnostic testing or blood film is an emergency, as disease can escalate rapidly, especially in children. Cases should be recalled immediately and hospital assessment organised.
- RDTs may remain positive for up to 4 weeks after successful malaria treatment. However, this should not preclude specialist review.

Malaria is managed at specialist level; contact a specialist urgently when testing is found to be positive.

Further information

For information on malaria screening, investigations and management, see the Immigrant Health Service website: rch.org.au/immigranthealth/resources.cfm?doc_id=11255.

More information on malaria treatment can be found in the eTherapeutic Guidelines: online.tg.org.au/complete/.

Other infections

There are limited paediatric data on the prevalence of hepatitis C virus (HCV) in refugees, although a recent study from Western Australia found HCV in 2% of African and 1% of Asian refugee children and adolescents.[54] Most refugee children and adolescents have evidence of past infection with hepatitis A, although few have a history of acute jaundice or cholestasis.

The prevalence of HIV infection is extremely low in paediatric refugee cohorts in Australia. Any child diagnosed with HIV requires urgent specialist referral.

Helicobacter pylori infection is common in refugee children and adolescents, with a prevalence of over 80% in recently arrived African groups.[61] The infection is usually asymptomatic, and its significance is unclear, although H. pylori is classed as a carcinogen, and treatment is recommended in adults. In practice, children seem to present with a combination of epigastric pain/tenderness, poor appetite, early satiety, and nausea/vomiting without reflux, usually with a family history of similar symptoms. These children should have specialist review. Faecal antigen testing (of fresh faecal specimens) for H. pylori has high sensitivity and specificity. International guidelines still recommend endoscopy as part of the diagnostic algorithm,[62] although in symptomatic children /adolescents offered treatment for H. pylori on spec (2 weeks duration triple therapy) the response is usually dramatic.

See Section 4 (p.79) for further details on specific conditions.

Oral health

See Section 4 > Oral Health (p.97).

Assessment of development and learning

Development may be affected by any combination of biological, environmental, social and emotional factors. Considerations in children of a refugee background include:

- biological: malnutrition, chronic disease, severe infection (including meningitis and cerebral malaria), hearing impairment, visual impairment, family history, prematurity
- environmental: living conditions, access to schooling, access to food, exposure to communicable diseases, migration and language transitions (and the age at which they occurred)
- social: loss of parents, parenting roles, family disruption, roles and responsibilities
- emotional: stress, trauma experiences, displacement, uncertainty around future, mental health problems.

Parent concern about a child's development is highly predictive of developmental delay/disability. However, absence of concern is not necessarily reassuring. Families with multiple children will usually readily identify if one child's development is different to their siblings.

Completing a thorough developmental and educational assessment in refugee children/adolescents presents challenges. As with any other child, a developmental and family history is essential. However, also consider migration, education and language transitions in relation to development. There are additional factors to consider in the aetiology of development/learning problems in refugee children, and basic screening for contributors such as visual/hearing impairment and mental health problems is frequently missed.

Immigrants usually achieve conversational proficiency 2–3 years after starting a new language. However, it takes much longer to achieve academic success in a new language, especially when schooling occurs in the new language. Large international studies (in advantaged children with age-appropriate schooling) show children aged 8–12 years at migration achieve academic language more quickly than other age groups, although they take 5–7 years to reach the standard of native-born speakers. Students from a refugee background are likely to have additional risk factors for educational disadvantage, including interrupted or inadequate schooling, financial hardship, mental health issues, cultural transitions and family stressors. Refugee students may be referred for assessment of developmental/learning issues several years after arrival.

There are many issues about the timing and validity of formal language or intelligence testing in a child's second language. Incorrect birth dates create additional complexity. A detailed assessment takes time and requires close liaison with the family, and the help of a skilled interpreter.

Adolescent development

Adolescent developmental issues include autonomy and independence, personal identity and body image, peer relationships and recreational goals, educational and vocational goals, and sexuality. Adolescents of a refugee background face all these transitions in addition to the transitions of resettlement. They are faced with balancing the values/expectations of their parents/cultural background with those of their new peers, while developing their own identity and learning a new language in a new schooling system.

Sexual health is an important area of adolescent health care, which is often missed. Australian research suggests many refugee young people have a poor understanding of sexual health and sexually transmitted infection (STI), and that they have limited opportunities to learn about sexual health before and after their arrival in Australia.[63] In this study, young people viewed school-based sexuality programs and health providers, including GPs, as useful and appropriate sources of information. They expressed a preference for clear factual information and gender-matched educators. Teenage pregnancy is also identified as an issue in refugee young people after settlement.[59]

KEY POINTS

Key points in adolescent sexual health

- Adolescents should be seen alone at some point during or soon after the initial screening assessment. This may be more acceptable to parents and adolescents if the health provider sees the family initially, and they are aware this will occur in the future.
- Define the bounds of confidentiality for the medical consultation and (separately) for working with interpreters.
- Consider STIs in refugee adolescents, including hepatitis B. A sensitive history is required, with adequate time.
- Don't assume prior sexual health knowledge, and offer opportunities for questions/discussion. Written resources for young people, and general resources are available, although these are not translated (see Resources).
- Translated information on sexual health, safe sex and specific STIs is also available (see Resources).
- Adolescents may have experienced sexual violence; unaccompanied adolescents are identified as particularly high-risk in the literature.
- Consider FGM in refugee girls/young women (see Section 4 > Female Genital Mutilation, p.89).

RESOURCES

- For translated information on safe sex and STIs in Amharic, Arabic, Somali, Thai, Tigrigna and other languages see the Victorian Department of Health Infectious diseases fact sheet series on the Department of Health website: ideas.health.vic.gov.au/diseases/language.asp.
- Other translated health information can be sourced using the links in Section 10 > Translated health information (p.318).

Mental health, emotional and behavioural issues

Children and adolescents of a refugee background will by definition have experienced conflict, significant upheaval and transitions that may affect their mental health. They may have witnessed or experienced physical or sexual violence or been exposed to life-threatening situations. They may have witnessed significant trauma, including seeing family members killed. Other experiences may include bereavement, being separated from family and community, disruption to schooling/routines, and prolonged periods of dislocation with uncertainty around the future. A history of these profoundly traumatic events is unlikely to be given during the initial assessment; it may emerge once a therapeutic relationship has developed.

Responses to trauma include depression, anxiety, post-traumatic stress, low self-esteem and guilt. These may manifest in a variety of ways including behavioural problems; problems with sleeping and eating, poor school performance, difficulty making friends and psychosomatic symptoms. Mental health should be considered in the broader family context; parents with mental health issues often have reduced coping and parenting skills.

There are difficulties with diagnosis and measurement of mental health issues across cultures. Studies of refugee children and adolescents report widely varying prevalence figures for mental health problems in different groups, and different rating scales are used. Figures range from 3–94% for PTSD, 4–47% for depression and 3–93% for anxiety problems.[59] The largest pooled analysis of mental health problems in people of a refugee background found the prevalence of PTSD was 11% in children.[64] Unaccompanied minors and people with uncertain visa status are at higher risk of mental health problems. Orphan relative visa holders are a group who warrant careful assessment, and who may not access (any) mainstream refugee settlement services.

General principles of management in children/adolescents experiencing trauma reactions include:

- addressing mental health issues in the whole family
- supporting primary attachments with significant people
- maintaining routine and preparing for changes
- reassuring them about the future
- encouraging them to express emotions and asking what they are thinking/feeling
- encouraging play in younger children and enjoyable activities in older children/adolescents

- providing feedback
- setting realistic goals for behaviour and avoiding overreacting to difficult behaviour during transition periods
- allowing time to adjust to life in Australia and time for the family to be together
- promoting good settlement (access to English teaching, education, and adequate support).

Some children, adolescents and families will require specialist mental health services or care.

Although refugees may have experienced significant trauma, there is good evidence that they often have great resilience and positive social adjustment. Experience of trauma does not always predict worse mental health outcomes, and mental health symptoms may not result in functional impairment. The majority of refugee children grow up to be well-adjusted adults and make significant contributions to their countries of resettlement.

Incorrect birth date

Refugee children and adolescents may have an incorrect birth date on their visa paperwork, which becomes the basis for all the official documentation in the country of settlement. This issue is not uncommon, and may have significant effects on school placement, developmental assessment (including formal assessments such as IQ testing) and access to Centrelink payments. The reasons for an incorrect birth date are often complex; it may be unknown, due to error, related to calendar discrepancies, or changed to due to family circumstances/conditions in country of origin. Any child with a birth date of 01/01/(year) is almost certainly younger. Families may be reluctant to raise this as an issue, and may be fearful of losing their visa as birthdates may not match on all documents. Often this emerges as an issue some years after settlement.

Correcting a birth date requires an assessment of the family narrative (including contextual migration events, birth order/ages of siblings), documenting any existing paperwork or known milestones, and an assessment of the child's age, pubertal stage and development.

A bone age X-ray is sometimes used in the specialist setting, but does not define the child's age. Bone age X-rays provide an estimate of bone age compared to chronological age. The Greulich and Pyle (GP) method is used most commonly (evaluating a single frontal X-ray of the left wrist). However, it is essential to note:

- the GP method is intended to assess skeletal age knowing the chronological age (not the reverse)
- the GP method is based on data from white American children from the 1930s; and considerable racial variation is found [65, 66, 67]
- the GP method is not precise, the margin of error is typically a 3–4 year range throughout childhood/adolescence
- skeletal maturity is affected by additional factors such as constitutional delay in maturation.

Bone age X-rays are most useful in a child who is clearly many years older or younger than their paperwork birth date.

Incorrect dates of birth can be formally changed using Form 424C under the Freedom of Information Act, through the Department of Immigration and Citizenship: www.immi.gov.au/allforms/pdf/424c.pdf.

Service systems

Table 5.10 highlights some key public service systems for children, adolescents and young people by age.

TABLE 5.10 Public service systems for children and adolescents

Service	Age range	Notes
Maternal and child health	0–5 years, increased involvement 0–3 years	Well child visits, parenting advice and development screening. Immunisation. Outreach support for families with complex needs. For information see the Department of Health and Ageing website: www.health.gov.au/internet/main/publishing.nsf/content/phd-child-health-index.
		See also the Immunise Australian Program webpage on the Department of Health and Ageing website: immunise.health.gov.au/.
Vision checks	All	Commercial optometry providers often offer Medicare billed optometry assessment, although spectacles may be costly. University optometry services/affiliated services such as the Australian College of Optometry* may be cheaper: aco.org.au.
		*Clients must have had a health care card for more than six month for access to spectacles from the Australian College of Optometry.
Audiology and hearing services	All	Australian hearing provides screening and ongoing assistance to young people (up to 26 years of age) with permanent and long term hearing loss. For local service providers visit Hearing Australia: www.ahyoungadults.com.au.
		For services in Victoria: www.rch.org.au/genmed/clinical.cfm?doc_id=2840.
		For services in NSW: www.sswahs.nsw.gov.au/sswahs/refugee/pdf/CEP/directory.pdf.
Asthma educators	All	Local schools, health services, or hospitals. For more information see the Australian Asthma and Respiratory Educators Association Inc. website: www.aareducation.com.
Carer allowance	<16 years (different pathways for those aged ≥16 years)	The Centrelink carer allowance is a supplementary payment for people caring for a child with a physical, intellectual or psychiatric disability, or specified medical condition. Permanent residents are eligible. Carer allowance is often forgotten in refugee children/families.
		www.centrelink.gov.au/internet/internet.nsf/payments/carer_allow_child.htm
Community health speech, OT, physiotherapy	0–6 or 0–school entry	Available from local community health service in some states, from public hospitals in others, and through some school-based programs, contact your state or territory department of health for further information.

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TABLE 5.10 Public service systems for children and adolescents continued

Service	Age range	Notes
Community dieticians and diabetes educators	All	Variable availability. Victorian community dietician details are available from the Royal Children's Hospital website: rch.org.au/immigranthealth/resources.cfm?doc_id=13746. To find a dietitian in your state see your state/territory department of health website, or the Dietitian Association of Australia website: daa.asn.au/.
Family and reproductive rights education program workers (FGM)	All women and girls	FARREP workers provide community education on female circumcision and individual support to people affected by it. The program is based in Victoria, but provides national advice and coverage: www.thewomens.org.au/farrep. Information is available in Amharic, Arabic, Somali and Tigrinya from this site.
Early intervention	0–6 years or 0–school entry	Services for children with developmental issues in multiple domains.
Condition-specific funding (FaHCSIA)	0–6 years	Funding packages are available for children with autism and some specific disabilities. Funding for children with autism: www.fahcsia.gov.au/sa/disability/progserv/people/HelpingChildrenWithAutism/Pages/default.aspx. Funding for children with disabilities: www.fahcsia.gov.au/sa/disability/progserv/people/betterstart/Pages/better_start_early_intervention.aspx.
Inclusion support program/ facilitators	Children attending childcare	Inclusion support for children with developmental issues/high support needs: www.deewr.gov.au/Earlychildhood/Programs/ChildCareforServices/SupportFamilyCCS/Pages/InclusionSupportProgram.aspx. Refugee children are a target group in the current strategy.
Kindergarten subsidy	Children attending kindergarten in Victoria	Kindergarten (in Victoria) is free for refugee and asylum seeker children under the Kindergarten fee subsidy: www.education.vic.gov.au/ecsmanagement/careankinder/funding/subsidy.htm. Translated information on why children should attend kindergarten, starting kinder, and the fee subsidy is available: www.education.vic.gov.au/earlychildhood/careandkinder/resources.htm.
	Preschool field officers	Preschool field officers support access and participation of children with additional needs in kindergarten: www.education.vic.gov.au/earlychildhood/additionalneeds/#4.
	Kindergarten inclusion support packages	To support children with severe disabilities or complex medical needs in attending kindergarten: www.education.vic.gov.au/ecsmanagement/careankinder/inclusion/disabilities.htm.

Continued next page

TABLE 5.10 Public service systems for children and adolescents continued

Service	Age range	Notes
Free Kindergarten Association (FKA) – Victoria	Children attending childcare, kindergarten and out of school hours care	The FKA provide training, resources and support to children/families, staff and organisations: www.fka.com.au/about-us. Can provide bilingual support; particularly to children at kindergarten: www.fka.com.au/casual-bilingual-program.
Schools	Children/ adolescents attending school	Resources for refugee students in government schools: www.education.vic.gov.au/studentlearning/programs/esl/refugees.
Outside school hours care (OSHC)	Children/ adolescents attending school	OSHC is available at many schools.
Homework clubs	Children/ adolescents attending school	Homework clubs are available for students in many areas, and may be a significant source of support/ community connections. Check with your local community health centre, local council or local migrant resource centre for details.
Child and family counselling services (except torture and trauma issues)	All	Local community health service or state/territory department of health website.

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TABLE 5.10 Public service systems for children and adolescents continued

Service	Age range	Notes
Child and Adolescent Mental Health Services (CAMHS)	0–15 or 0–18, varies, moving towards 0–25 in	CAMHS services operate across Victoria: www.health.vic.gov.au/mentalhealth/services/child/index.htm. In WA CAMHS have three main sites: Princess Margaret Hospital, Family Pathways, FEIP Lemnos Hospital. See the WA Department of Health website: www.health.wa.gov.au/services/detail.cfm?Unit_ID=370. South Australian service information is on the Women and Children's Health Network website: www.wch.sa.gov.au/services/az/divisions/mentalhealth/index.html. NSW CAMHS information can be obtained from the NSW Department of Health website: www.health.nsw.gov.au/pubs/2011/camhs_nov11.html. Tasmanian referral information is listed on the Tasmanian Department of Health and Human Services website: www.dhhs.tas.gov.au/mentalhealth/mhs_tas/gvt_mhs/child_and_adolescent_mental_health_services The Queensland Division of Child and Youth Mental Health Services (CYMHS) provides services for the 0-18 age group. Information: www.health.qld.gov.au/rch/professionals/cymhs.asp. NT has some mental health support services for children and adolescents, for further information visit the NT Government Department of Health website: www.health.nt.gov.au/Mental_Health/index.aspx.
Headspace	12–25 years	Headspace is the national youth mental health foundation, with a network of drop in centres and web-based resources.
Torture and trauma support services	All	For services in your state visit the Forum of Australian Services for Survivors of Torture and Trauma: www.fasstt.org.au.
Youth workers (includes youth counselling service)	14-25 years	Local community health service or state/territory department of health or childhood development website.

References

1. Australian Government. (2011). Age on arrival by migration stream. Retrieved from: < www.immi.gov.au/living-in-australia/delivering-assistance/settlement-reporting-facility >.
2. Australian Government. (2009). Instructions for medical and radiological examination of Australian visa applicants. Retrieved from: < www.immi.gov.au/gatewaysa/panel_doctors/conducting_medicals/instructions >.
3. Australian Government. (2011). Fact Sheet 67a – Pre-Departure Medical Screening (PDMS). Retrieved from < www.immi.gov.au/media/fact-sheets/67a_pdms.htm >.
4. Murray RJ., Davis JS., Krause V., Biggs, B-A., Lemoh, C., Benson, J. & Burgner (2009). 'Diagnosis, management and prevention of infections in recently arrived refugees. Sydney: Australasian Society for Infectious Diseases'. Dreamweaver Publishing Pty Ltd. Retrieved from: < www.asid.net.au/downloads/RefugeeGuidelines.pdf >.
5. Murray RJ., Davis JS., Burgner DP., et al. (2009). 'The Australasian Society for Infectious Diseases guidelines for the diagnosis, management and prevention of infections in recently arrived refugees: an abridged outline'. Medical Journal of Australia, 190,421-5.
6. Royal Children's Hospital. (2011). Initial post-arrival health assessment. Retrieved from: < rch.org.au/immigranthealth/resources.cfm?doc_id=10814 >.
7. Geltman PL., Brown MJ. & Cochran J. (2001). 'Lead poisoning among refugee children resettled in Massachusetts, 1995 to 1999'. Pediatrics,108,158-62.
8. Hayes, EB., Talbot, SB., Matheson, ES., Pressler, HM., Hanna, AB. & McCarthy CA. (1998). 'Health status of pediatric refugees in Portland'. Archives of Pediatriatrics and Adolescent Medicine, 152, 564-8.
9. Leads from the MMWR. (1983). Folk remedy-associated lead poisoning in Hmong children. Centers for Disease Control, 250, 3149-50.
10. Simon, P., Zimmerman, A., O'Connor, W. & Vang, C. (1989). 'The risk of lead poisoning among southeast Asian refugee children in Rhode Island 1984-1988'. Rhode Island Medical Society Journal, 72(8), 283-7.
11. Mitchell, T., Jentes, E., Ortega, L., Bajcevic, P., Jones, W., Parr, V... & Painter, J. (2009). 'Elevated Blood Lead Levels among Children in Refugee Camps Mae La, Umpiem, and Nupo Refugee Camps, Tak Province, Thailand' June 2–19. Atlanta: Centers for Disease Control and Prevention. Retrieved from: < www.doh.state.fl.us/disease_ctrl/Refugee/Recent_Letter/Lead_Levels_Burmese_Children.pdf >.
12. Ritchey, MD., Scalia Sucosky, M., Jefferies T., McCormick, D., Hesting, A., Blanton, C... & Jean Brown, M. (2012). 'Lead poisoning among Burmese refugee children–Indiana, 2009'. Pediatrics 129, e392-e399.
13. Australian Government. (2008). The Australian Immunisation Handbook (9th ed.).Canberra: Australian Government, Department of Health and Ageing and National Health and Medical Research Council. Retrieved from: < www.health.gov.au/internet/immunise/publishing.nsf/content/handbook-home >.
14. Victorian Department of Health. (2011). Transition to Prevenar 13® on the National Immunisation Program. Information for immunisation providers. Victoria. Retrieved from: < docs.health.vic.gov.au/docs/doc/EC2A346DFCE9FBA4CA2578B200123F36/$FILE/Transition to Prevenar 13 fact sheet 13.pdf >.
15. Department of Human Services. (2006). Management, control and prevention of tuberculosis. Guidelines for healthcare providers (2002–2005). Melbourne: Rural and Regional Health and Aged Care Service Division, Victorian Government, Department of Human Services.
16. McGillivray, G., Skull, SA., Davie, G., Kofoed, SE., Frydenberg, A., Rice, J...& Carapetis, JR. (2007). 'High prevalence of asymptomatic vitamin D and iron deficiency in East African immigrant children and adolescents living in a temperate climate'. Archive of Disease in Childhood, 92, 1088-93. Doi:10.1136/adc.2006.112813

17. Denburg, A., Rashid, M., Brophy, J., Curtis, T., Malloy, P., Audley, J...& Banerji, A. (2007). 'Initial health screening results for Karen refugees: a retrospective review'. Canada Communicable Disease Report, 33(13), 16-22.
18. Renzaho, AM., Gibbons, C., Swinburn, B., Jolley, D. & Burns, C. (2006). 'Obesity and undernutrition in sub-Saharan African immigrant and refugee children in Victoria, Australia'. Asia Pacific Journal of Clinical Nutrition, 15(4), 482-90.
19. Graham, EA. (2005). 'Economic, racial, and cultural influences on the growth and maturation of children'. Pediatrics in review / American Academy of Pediatrics, 200(26), 290-4.
20. Popkin, BM. & Udry, JR. (1998). 'Adolescent obesity increases significantly in second and third generation U.S. immigrants: the National Longitudinal Study of Adolescent Health'. Journal of Nutrition, 1998,128, 701-6.
21. Southcombe, F. (2008). 'We buy food if there is money left from rent and bills, but there is no money left'. Discussion paper and presentation. Fairfield Nutrition Project. Retrieved from: < http://www.ncoss.org.au/bookshelf/conference/download/perspectives_on_poverty/faye-southcombe-oct07.pdf >.
22. Gallegos, D., Ellies, P. & Wright, J. (2008). 'Still there's no food! Food insecurity in a refugee population in Perth, Western Australia'. Nutrition and Dietetics, 65, 78-83.
23. WHO Multicentre Growth Reference Study Group. (2006). 'Assessment of differences in linear growth among populations in the WHO Multicentre Growth Reference Study'. Acta Paediatriaca, 450, 56-65.
24. Kuczmarski, RJ., Ogden, CL. & Guo, SS. (2002). 2000 CDC Growth Charts for the United States: methods and development. Vital and Health Statistics, 11(246), 1-190. Retrieved from: < www.cdc.gov/nchs/data/series/sr_11/sr11_246.pdf >.
25. Commonwealth Scientific Industrial Research Organisation (CSIRO), Preventative Health National Research Flagship, and the University of South Australia. (2008). 2007 Australian National Children's Nutrition and Physical Activity Survey- Main Findings. Retrieved from < www.health.gov.au/internet/main/publishing.nsf/Content/66596E8FC68FD1A3CA2574D50027DB86/$File/childrens-nut-phys-survey.pdf >.)
26. Paxton, GA., Sangster, KJ., Maxwell, EL., McBride, CRJ. & Drewe, R.H. (2012). 'Post arrival health screening in Karen refugees in Australia'. Submitted for publication 2011.
27. Roth, DE. (2011). 'Vitamin D supplementation during pregnancy: safety considerations in the design and interpretation of clinical trials'. Journal of Perinatology, 31, 449-59.
28. Holick, MF. (2004). 'Sunlight and vitamin D for bone health and prevention of autoimmune diseases, cancers, and cardiovascular disease'. The American journal of Clinical Nutrition, 80 (6 suppl), 1678S-88S.
29. 29 Springbett, P., Buglass, S. & Young AR. (2010) 'Photoprotection and vitamin D status'. Journal of Photochemistry and Photobiology B, 101, 160-8.
30. Nowson, CA. & Margerison, C. (2002). 'Vitamin D intake and vitamin D status of Australians'. Medical Journal of Australia, 177, 149-52.
31. Hollis, BW., Roos, BA., Draper, HH. & Lambert PW. (1981). 'Vitamin D and its metabolites in human and bovine milk'. The Journal of Nutrition, 111, 1240-8.
32. Ross, CA., Taylor, CL., Yaktine, AL. & Del Valle, HB. (eds.) (2010). Dietary reference intakes for calcium and vitamin D. Committee to Review Dietary Reference Intakes for Calcium and Vitamin D, Food and Nutrition Board. Washington: Institute of Medicine, National Academies Press.
33. Johnson, D. (2007). Rates of infectious diseases and nutritional deficiencies in newly arrived African refugees. Central North Adelaide Health Service, Government of South Australia. Retrieved from: < www.sdgp.com.au/client_images/107719.pdf >.
34. Skull, S., Ngeow, J., Biggs, B-A., Street, A. & Ebeling, PR. (2003). 'Vitamin D deficiency is common and unrecognized among recently arrived adult immigrants from the Horn of Africa'. International Medical Journal, 33(1-2), 47–51.
35. Benitez-Aguirre PZ., Wood NJ., Biesheuvel C., Moreira C. & Munns, CF. (2009). 'The natural history of vitamin D deficiency in African refugees living in Sydney'. Medical Journal of Australia, 190, 426-8.

36. Gray K., Wood N., Gunasekera H., Sheikh, M., Hazleton, B., Barzi, F. & Isaacs, D. (2011). 'Vitamin D and Tuberculosis Status in Refugee Children'.Pediatric Infectious Diseases Journal. [post acceptance 23 December 2011].
37. Sheikh, M., Pal, A., Wang, S., MacIntyre, CR., Wood, NJ., Isaacs, D...& Howell, A. (2009). 'The epidemiology of health conditions of newly arrived refugee children: a review of patients attending a specialist health clinic in Sydney'. Journal Paediatrics and Child Health, 45(9), 509-13.
38. Bowyer, L., Catling-Paull, C., Diamond, T., Homer, C., Davis, G. & Craig, ME. (2009). 'Vitamin D, PTH and calcium levels in pregnant women and their neonates'. Clinical Endocrinology (Oxf), March 70(3), 372-7.
39. Grover, SR. & Morley, R. (2001). 'Vitamin D deficiency in veiled or dark skinned pregnant women'. Medical Journal of Australia, 171, 251-2.
40. Judkins, A. & Eagleton, C. (2006). 'Vitamin D deficiency in pregnant New Zealand women'. New Zealand Journal of Medicine, 119, U2144.
41. Nozza, JM. & Rodda, CP. (2001). 'Vitamin D deficiency in mothers of infants with rickets'. Medical Journal of Australia, 175, 253-5.
42. Robinson, PD., Hogler, W., Craig, ME., Verge, CF., Piper, AC., Woodhead, HJ... & Ambler, GR. (2005). 'The re-emerging burden of rickets: a decade of experience from Sydney'. Archives of disease in childhood, 91, 564-8.
43. Tiong, ACD., Patel, MS., Gardiner, J., Ryan, R., Linton, KS, Scopel, J. & Biggs, B-A. (2006). 'Health issues in newly arrived African refugees attending general practice clinics in Melbourne'. Medical Journal of Australia, Dec 4-18, 185(11/12), 602-606.
44. Lozoff, B. & Georgieff, MK. (2006). 'Iron deficiency and brain development'. Seminars in Pediatric Neurology, 13, 158-65.
45. US Committee on Environmental Health (2005). 'Lead exposure in children: prevention, detection, and management'. Pediatrics, 116, 1036-46.
46. Centers for Disease Control. (2011). CDC Recommendations for Lead Poisoning Prevention in Newly Arrived Refugee Children. Retrieved from: < www.cdc.gov/nceh/lead/Publications/RefugeeToolKit/pdfs/CDCRecommendations.pdf >.
47. Martin, JA. & Mak, DB. (2006). 'Changing faces: a review of infectious disease screening of refugees by the Migrant Health Unit, Western Australia in 2003 and 2004'. Medical Journal of Australia, Dec 4-18, 185(11/12), 607-610.
48. McMahon, BJ., Alward, WL., Hall, DB., Heyward, WL., Bender, TR., Francia, DP. & Maynard, JE. (1985). 'Acute hepatitis B virus infection: relation of age to the clinical expression of disease and subsequent development of the carrier state'. Journal of Infectious Disease,151, 599-603.
49. Haber, BA., Block, JM., Jonas, MM., Karpen, SJ. & London, WT. (2009). 'Recommendations for screening, monitoring, and referral of pediatric chronic hepatitis B'. Pediatrics, 124(5), e1007-13.
50. Bosch, FX., Ribes, J., Cleries, R. & Diaz M. (2005). 'Epidemiology of hepatocellular carcinoma'. Clinical Liver Disease, 9, 191-211.
51. Lok, AS. & McMahon, BJ. (2009). 'Chronic hepatitis B: update 2009'. Hepatology, 50, 661-2.
52. Davis, J. & Webber, MA. (2006). Prospective audit of infectious diseases in 222 newly arrived African refugees. Poster presented at the Royal Australasian College of Physicians Annual Scientific Meeting, Cairns.
53. Cooley, L., Nott, L., Williams, M. & McGregor, A. (2004). Prevalence of selected infectious diseases in an African refugee population. Poster presented at Australian Society for Infectious Diseases Incorporated Annual Scientific Meeting, Alice Springs.
54. Lucas, M., Nicol, P., McKinnon, E., Whidboren, R., Lucas, A., Thambiran, A., Burgner, D... & French, M. (2010). 'A prospective large-scale study of methods for the detection of latent Mycobacterium tuberculosis infection in refugee children'. Thorax, 65, 442-8.
55. Johnston, V., Smith, L. & Roydhouse H. (2011). 'The health of newly arrived refugees to the Top End of Australia: results of a clinical audit at the Darwin Refugee Health Service'. Australian Journal of Primary Health, published online December 2011. < doi.org/10.1071/PY11065 >
56. King, K. & Vodicka,P. (2001). 'Screening for conditions of public health importance in people arriving in Australia by boat without authority'. The Medical Journal of Australia, 175, 600-2.

57. Paxton, GA., Rice, J., Davie, G., Carapetis, J.R... & Skull S.A. (2011). 'East African immigrant children in Australia have poor immunisation coverage'. Journal of Paediatrics and Child Health, 47, 888-92.
58. Skull, SA., Ngeow, JY., Hogg, G. & Biggs, B-A. (2008). 'Incomplete immunity and missed vaccination opportunities in East African immigrants settling in Australia'. Journal of Immigrant Minority Health, 10, 263-8.
59. Paxton, GA., Smith, N., Win, AK., Mulholland N. & Hood S. (2011). Refugee status report. A report on how refugee children and young people in Victoria are faring. Melbourne: Victorian Government, Department of Education and Early Childhood Development (DEECD).
60. Cherian, S., Fagan, JM., Thambiran, A., Geddes, J. & Burgner, D. (2008). 'Severe Plasmodium falciparum malaria in refugee children despite reported predeparture antimalarial treatment'. Medical Journal of Australia, 185, 611.
61. Cherian, S., Forbes, DA., Sanfilippo, FM., Cook AG. & Burgner, DP. (2008). 'The epidemiology of Helicobacter pylori infection in African refugee children resettled in Australia'. The Medical Journal of Australia, 189, 438-41.
62. Koletzko, S., Jones, NL., Goodman, KJ., Gold, B., Rowland, M., Cadranel, S...& Odera, G. (2011). 'Evidence-based guidelines from ESPGHAN and NASPGHAN for Helicobacter pylori infection in children'. Journal Pediatrics Gastroenterological Nutrition, 53, 230-43.
63. McMichael, C. (2008). Promoting sexual health amongst resettled youth with refugee backgrounds. Melbourne: Latrobe University, Refugee Health Research Centre.
64. Fazel, M., Wheeler, J. & Danesh, J. (2005). 'Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review'. Lancet, 365, 1309-14.
65. Mora, S., Boechet, MI., Pietka, EWA, Huang, HK. & Gilsanz, V. (2001). 'Skeletal Age Determinations in Children of European and African Descent: Applicability of the Greulich and Pyle Standards'. PediatricResearch, 50(50), 624-628.
66. Ontell, FK., Ivanovic, M., Albin, DS. & Barlow, TW. (1996). 'Bone Age in children of diverse ethnicity'. American Journal of Roentgenology, 167, 1395-1398. Retrieved from: < www.ajronline.org/content/167/6/1395.full.pdf >.
67. Chiang, K-H., Chou, ASB., Yen, PS., Ling, CM., Lin, CC., Lee, CC. & Chang, PY. (2005). 'The reliability of using Greulich-Pyle method to determine children's bone age in Taiwan'. Tzu Chi Medicine Journal. 17, 417-420.

Section 6:
An approach to refugee health assessment



This section provides information on performing a comprehensive post-arrival health assessment for refugees and other humanitarian entrants under MBS Items 701, 703, 705 and 707. This approach is also instructive in performing health assessments for asylum seekers. The first part of this section provides information on some of the pre-arrival medical examinations that newly arrivals may have undergone.

Medical information here relates primarily to the recently arrived refugee client. However, it may also be relevant to other clients from refugee backgrounds.

Further useful information for performing the initial refugee health assessment can be found in the following sections of this guide:

- Section 4 for common adult health concerns
- Section 5 for health concerns of children and adolescents
- Section 7 which explores issues in consultation and management, as well as Medicare Benefit Scheme Item numbers
- Section 10 for links to country profiles and background information on the countries of origin of many people of refugee background

Visa medical examination and departure health check (DHC)

Overview

As part of obtaining their offshore Humanitarian Visa to Australia, entrants will have undergone a medical examination to determine if they have any diseases or conditions which would represent a threat to public health in Australia, place an economic burden on the health system, or prejudice the access of Australian citizens to health care and community services.[1,2]

There are no medical conditions that specifically preclude selection for the Australian humanitarian visa program other than Tuberculosis (TB). In the case of communicable diseases (e.g. active tuberculosis), an applicant will be expected to undergo treatment before travelling to Australia. In cases where TB disease is deemed inactive, applicants may be approved for entry to Australia on the condition that they present for follow-up monitoring (a Health Undertaking). See The Health Undertaking (p.230).

Those on a Health Undertaking are to present to a local Health Undertaking Service within a month of arrival in Australia. It is worth noting that the visa medical may have been undertaken many months before travelling to Australia.

Clients also undergo a departure health check (DHC) 72 hours prior to travelling to Australia. The tests undertaken, as well as the Health Manifest that accompanies these tests, are detailed in the following pages. As part of the DHC clients with a chronic disease will be supplied with 2 weeks' worth of medication, which should be reviewed by a GP as soon as possible after arrival in Australia. Some people receive a Health Alert at this time, and may be required to present to a GP within 24-72 hours of arrival in Australia.

Visa medical examination

Table 6.1 shows the tests that are usually performed as a requirement for application for a Humanitarian Visa.

For more information on the visa medical see the following DIAC documents:

- Department of Immigration and Citizenship (2010) The Health Requirement Fact Sheet No. 22 DIAC www.immi.gov.au/media/fact-sheets/22health.htm.
- Department of Immigration and Citizenship (2011) Health Requirement for permanent entry to Australia, Form 1071i, DIAC. http://www.immi.gov.au/allforms/pdf/1071i.pdf

TABLE 6.1 Tests performed at visa medical examination

Chest X-ray	Visa applicants aged 11 years or older. Those under 11 also undergo this, if there are indications or they have TB or a history of contact with TB.
HIV serology	All applicants aged 15 years or older All children for adoption All unaccompanied refugee minor children Others if clinical indications require it
VDRL – syphilis serology	Any applicant suspected of having an STI. All refugee applicants aged over 15 who have lived in camp-like conditions.
Hepatitis B and C serology	All pregnant women All children for adoption All unaccompanied refugee minor children Others if clinical indications require it
Height and weight	All applicants
Full medical examination	All applicants

The Health Undertaking

Following their visa medical examination, some humanitarian entrants will have been asked to sign an undertaking that they will contact the Australian Government Health Undertaking Service for follow-up monitoring within a specified time of arriving in Australia – usually 4 weeks. A toll-free number is included on the undertaking form for this purpose. The following new arrivals may be on a Health Undertaking:

- people who had tuberculosis (TB) detected in the course of overseas medical examinations screening which was subsequently treated
- people whose chest X-ray showed an abnormality suggestive of inactive TB
- people whose chest X-rays conducted as part of the overseas medical examinations were of poor quality
- people who have tested positive for hepatitis B, or HIV
- people receiving treatment for leprosy (this form of undertaking is rare).

Owing to language barriers, stress and the confusing array of processes experienced by many refugees prior to their journey to Australia and on arrival, they may not fully understand the Health Undertaking or their obligations in signing it.

For further information about a person on a Health Undertaking, contact the public health unit in your state or territory health department. Clients may need support or assistance to call the Health Undertaking Service on 1800 811 334.

72 hour departure health check (DHC)

The Department of Immigration and Citizenship offers the DHC to refugee and humanitarian program entrants. The DHC is normally conducted 72 hours prior to departure for Australia. The service was previously known as the pre-departure medical screening (PDMS). The purpose of the DHC is to ensure that refugee and humanitarian program clients are fit to travel, to check for communicable diseases, to provide vaccination and treatment for parasites and to facilitate health care after arrival in Australia

Not all humanitarian entrants undergo the DHC although about 90% of refugees and 65% of special humanitarian program clients undertake them. The DHC is voluntary.

Tests are currently conducted in Ethiopia, Ghana, Guinea, Kenya, India, Iran, Jordan, Lebanon, Nepal, Sierra Leone, South Africa, Syria, Tanzania, Uganda, Zambia and Zimbabwe. Even in these countries there is not a 100% take-up rate of the DHC. Applicants are counselled and given records about any issues arising from their health screening and treatment.

What is involved in pre-departure medical screening?

The departure health checks historically had varied depending on the country where it was undertaken (formerly referred to as the 'long' and 'short' PDMS).

This distinction no longer exists and the DHC will be the same wherever it is undertaken.

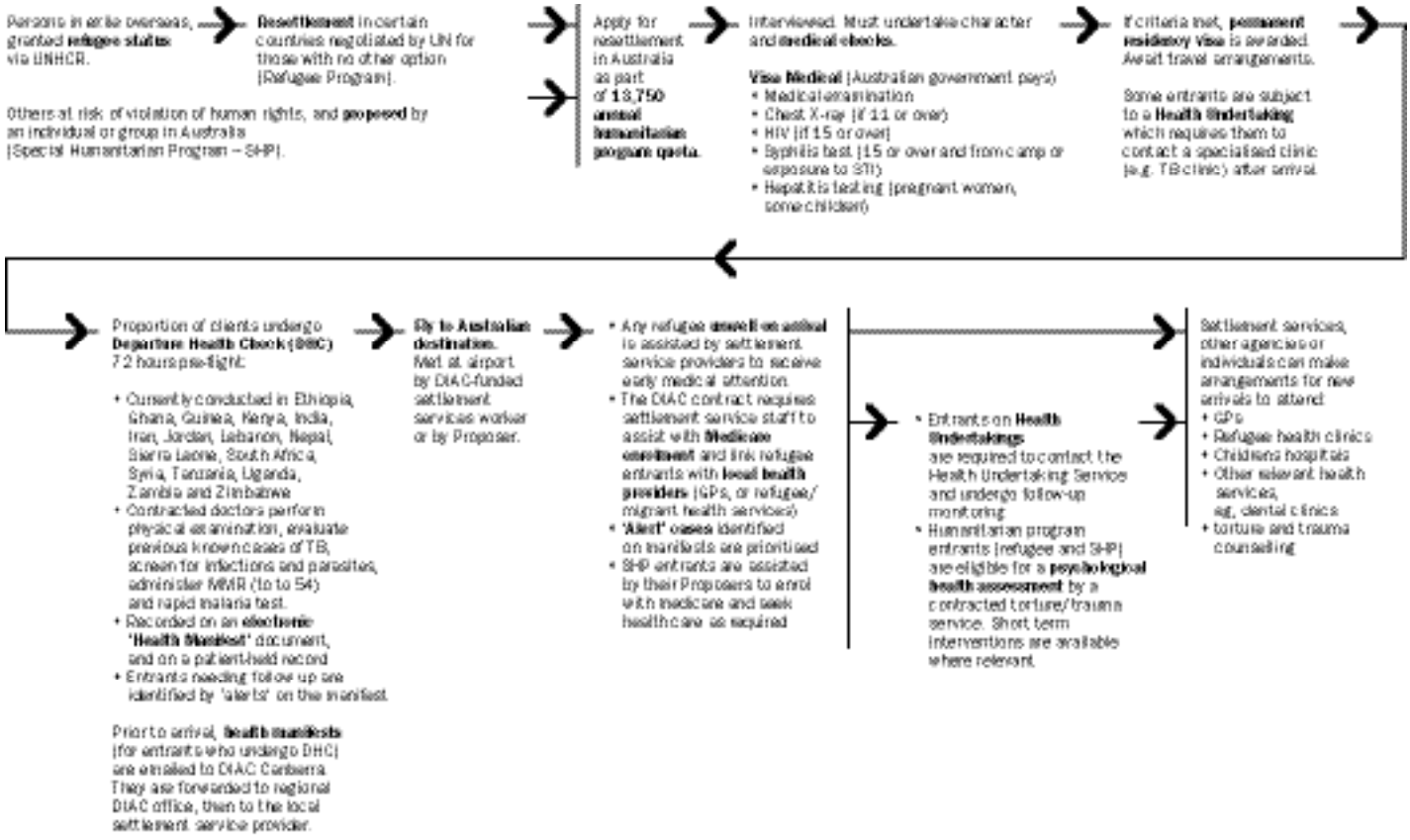
The DHC requires contracted health service providers to:

- conduct a physical examination
- treat parasites and infections
- evaluation previously known cases of TB
- administer immunisation against measles, mumps and rubella (up to age 54 years)
- perform rapid diagnostic tests for malaria in endemic regions
- perform any additional screening or treatment deemed necessary at the time of the examination.

Examples of additional screening or treatment that may be deemed necessary include: stable malignancy, complicated pregnancy, CVA older than two weeks, stable ischaemic heart disease, recurring treated malaria, stable psychotic illness, dependency syndromes and uncontrolled diabetes.

Figure 6.1 details the screening protocols and health processes for Humanitarian Program entrants to Australia.

FIGURE 6.1 Pathway and health processes for humanitarian program entrants to Australia


Persons in or le overseas, granted refugee status via UNHCR.
Resettlement in certain countries negotiated by UN for those with no other option (Refugee Program).
Others at risk of violation of human rights, and proposed by an individual or group in Australia (Special Humanitarian Program – SHP).
Apply for resettlement in Australia as part of 13,750 annual humanitarian program quota.
Interviewed. Must undertake character and medical checks.
Visa Medical (Australian government pays)
• Medical examination
• Chest X-ray (if 11 or over)
• HIV (if 15 or over)
• Syphilis test (15 or over and from camp or exposure to STI)
• Hepatitis testing (pregnant women, some children)
If criteria met, permanent residency Visa is awarded. Await travel arrangements.
Some entrants are subject to a Health Undertaking which requires them to contact a specialised clinic (e.g. TB clinic) after arrival.
Proportion of clients undergo Departure Health Check (DHC) 72 hours pre-flight:
• Currently conducted in Ethiopia, Ghana, Guinea, Kenya, India, Iran, Jordan, Lebanon, Nepal, Sierra Leone, South Africa, Syria, Tanzania, Uganda, Zambia and Zimbabwe
• Contracted doctors perform physical examination, evaluate previous known cases of TB, screen for infections and parasites, administer MMR (to to 54) and rapid malaria test.
• Recorded on an electronic 'Health Manifest' document, and on a patient-held record
• Entrants needing follow up are identified by 'alerts' on the manifest
Prior to arrival, health manifests (for entrants who undergo DHC) are emailed to DIAC Canberra. They are forwarded to regional DIAC office, then to the local settlement service provider.
Fly to Australian destination. Met at airport by DIAC-funded settlement services worker or by Proposer.
• Any refugee unwell on arrival is assisted by settlement service providers to receive early medical attention
• The DIAC contract requires settlement service staff to assist with Medicare enrolment and link refugee entrants with local health providers (GPs, or refugee/migrant health services)
• 'Alert' cases identified on manifests are prioritised
• SHP entrants are assisted by their Proposers to enrol with medicare and seek health care as required
• Entrants on Health Undertakings are required to contact the Health Undertaking Service and undergo follow-up monitoring
• Humanitarian program entrants (refugee and SHP) are eligible for a psychological health assessment by a contracted torture/trauma service. Short term interventions are available where relevant.
Settlement services, other agencies or individuals can make arrangements for new arrivals to attend:
• GPs
• Refugee health clinics
• Childrens hospitals
• Other relevant health services, eg, dental clinics
• torture and trauma counselling

The Health Manifest

The Health Manifest template is an electronic Excel spreadsheet created for each family, and includes personal and health information including testing and treatment administered during the DHC and notification of a Red or General Alert. The Health Manifest and DHC results are provided to refugee and special humanitarian entrants. A copy of the Health Undertaking form (Form 815) is also included where relevant.[1]

A copy of the Health Manifest may be provided to the client's DIAC-funded settlement case coordinator in Australia, who is responsible for assisting refugee entrants to access health care.

All documents are given to the client, often in a sealed envelope marked 'medical in-confidence'.

Health alerts

An alert system provides notification of any potentially serious health conditions. The alerts are listed on the Health Manifest in the 'alerts' column.

Red Alerts: Any cases requiring follow-up medical attention within 72 hours of arrival in Australia, or cases with serious medical conditions. The reasons should be detailed in the Health Manifest's alert column.

Red alerts are applicable to clients with chronic severe medical conditions which:

- cannot be improved substantially with treatment,
- present a risk for travel or
- require urgent medical attention on arrival.

Examples include: sever chronic airways disease, systematic heart failure, other organ failure and end stage malignancy.

General Alerts: Any cases requiring follow-up medical attention within 72 hours of arrival, or cases with serious medical conditions. The reasons should be detailed in the Health Manifest's alert column.

RESOURCES

- Red and General Alerts for humanitarian entrants: www.refugeehealthnetwork.org.au/_literature_63038/Red_and_General_Alerts_Feb_2010

PRACTICE TIP

At their first appointment, check with the refugee client or their settlement case manager (or proposer) if they have been given any medical documents. The client may not be aware that they need to be shown to a GP.

Establish if the person signed a Health Undertaking, and if so, whether they have contacted the Health Undertaking Service.

Health assessment of asylum seekers

People who are asylum seekers will not have undergone the overseas medical screening conducted with Humanitarian Program entrants. However, once they apply for refugee status they are required to undertake a visa medical examination.

Medical screening for people who arrive in Australia with valid entry documents (such as student or tourist visa) and who subsequently seek asylum differs to the screening of those who arrived without entry documents.

It is important to understand the varied health screening experiences of asylum seeker clients when performing a health assessment.

ASYLUM SEEKERS LIVING IN THE COMMUNITY

- People who arrive with valid entry documentation (typically by plane) may have undergone some pre-arrival screening in order to be granted a student, tourist or other visa. When these clients lodge their asylum claim they have to undergo medical tests for their application. The eligibility of asylum seekers to access healthcare in Australia is the subject to policy change. Since 2009, many asylum seekers living in the community are eligible for Medicare.

ASYLUM SEEKERS IN IMMIGRATION DETENTION

- Asylum seekers who arrive without valid entry documents (typically by sea) are usually subject to periods of immigration detention. Health screening is undertaken by government contractors at this time. See Health assessment of asylum seekers in Immigration Detention in Australia.

ASYLUM SEEKERS IN COMMUNITY DETENTION

- Some asylum seekers who have been in immigration detention facilities are released into the community under the Community Detention Program, which is facilitated by the Red Cross. These clients will have undergone screening during immigration detention. Red Cross (or its contracted partners) assist these people to access GPs who are funded to provide services to this client group under contract to IHMS. See Section 11 for referral information for Red Cross.

ASYLUM SEEKERS ON BRIDGING VISA POST DETENTION

- Some asylum seeking families or individuals may be living in the community on a Bridging Visa E after periods of immigration detention. Holders of this BVE have work rights and are provided access to Medicare.

For information on health entitlements and access for asylum seekers in Australia see Fact Sheet 62 – Assistance for Asylum Seekers in Australia on the Department of Immigration and Citizenship website: www.immi.gov.au/media/fact-sheets/62assistance.htm.

See also the Victorian Refugee Health network factsheets on asylum seeker health care: www.refugeehealthnetwork.org.au

Asylum seekers whose applications are recognised are granted a permanent protection visa and have full Medicare access. People who hold a protection visa are eligible for the refugee health assessment under MBS Items 701, 703, 705, 707 as outlined in this Section.

For more information on asylum seekers see p.18.

Health assessment of asylum seekers in Immigration Detention in Australia[3]

Asylum seekers who arrive by sea will typically have spent time in immigration detention on Christmas Island and may also have spent time in mainland detention centres. On arrival an initial health assessment is conducted to identify conditions that will require attention. Any ongoing medical treatment and care is provided if required or if a client seeks it. The Department of Immigration and Citizenship (DIAC) has contracted the International Health and Medical Services (IHMS) to provide initial health assessments and catch-up immunisations to asylum seekers detained both in the Immigration Detention Centres (IDCs) and in Alternative Places of Detention (APODs). The Indian Ocean Territories Health Service (IOTHS) runs the local hospital on Christmas Island. The hospital provides in-patient services as required for all permanent and temporary residents of the island. All Christmas Island clients who are granted a protection visa (866 visa) and transferred to mainland Australia are provided with a Health Discharge Assessment conducted by IHMS, which includes:

- a client's health summary
- a fitness-to-travel assessment
- advice on ongoing/post-arrival health care needs.

The Health Discharge Assessment is provided directly to DIAC, and often a copy is given to the client to inform health services following arrival on the mainland. This assessment may be available on request, and can be used to guide assessment and avoid repeat investigations. More information regarding health checks undertaken on Christmas Island is available at the Victorian Refugee Health Network website: www.refugeehealthnetwork.org.au/LiteratureRetrieve.aspx?ID=76724.

RESOURCES

- Immunisation for residents living in community detention: www.refugeehealthnetwork.org.au/_literature_93499/Community_Detention_Immunisation_Guidelines
- Asylum Seekers – A fact sheet for Victorian Health Services: www.refugeehealthnetwork.org.au/_literature_90300/VRHN_AS_Factsheet_(added_11_Aug_2011)

KEY POINTS

Key points in health assessment of asylum seekers

- Asylum seekers have had varied access to healthcare and health assessment in Australia.
- An asylum seeker may be reluctant to disclose information about their health, fearing that this may prejudice their application for permanent residency.
- Ensure that you maintain detailed notes for asylum seeker clients, as these may be of assistance in the client's application for permanent residency.
- Where appropriate, you may be in a position to offer an asylum seeker a report to assist them in their application for refugee status or permanent residence on humanitarian grounds. DIAC recommends that doctors do not act as advocates in this regard, but rather provide clear and complete medical reports for consideration. See Section 9 > Asylum Seekers Medical Documentation (p.305).
- Asylum seekers may or may not have access to Medicare depending on their migration status. Asylum Seekers who are ineligible for Medicare may be eligible for the Asylum Seeker Assistance Scheme (ASAS) or the Community Assistance Scheme (CAS) facilitated by Red Cross. Consider referral to ASAS or CAS (see Section 11, p.323).
- Asylum seekers may present after periods of detention in immigration detention facilities.
- In most states and territories asylum seekers have priority or assisted access to health centres, dental care, immunisation catch-up and ambulance cover. See your state or territory's health ministry website for more details.

A guide to performing the post-arrival health assessment for refugees and other humanitarian entrants (Medicare Items 701, 703, 705 and 707)

Comprehensive health assessments promote a complete review of past and current health problems, systematic planning of further management and preventative health care. This is particularly important if the client is a refugee as:

- humanitarian entrants have relatively poor health status and are likely to have had limited access to health care[4, 5, 6] (See Section 1 > Special health concerns of refugees, p.23)
- some health problems experienced by people from refugee backgrounds are asymptomatic, but nonetheless may have serious long-term health consequences (e.g. intestinal parasitic infection, adult vitamin D deficiency, hepatitis B)[7, 8]
- it optimises the opportunity for early intervention, helping to ensure that physical and psychological problems do not become enduring barriers to settlement
- sensitively administered, a thorough medical examination can contribute to a person's psychological recovery.

This section provides a specific guide to each of the content areas outlined in the Medicare schedule for the health assessment as it applies to refugees and other humanitarian entrants, Items 701 (brief <30mins), 703 (standard 30–45 mins), 705 (long 45–60 mins) and 707 (prolonged >60mins). These items cover taking a history, examination, initiating interventions, referrals and a basic preventative health management plan. The prolonged assessment, item 707 performed over a series of visits, is preferable for refugees, as it includes an assessment of psychosocial functioning and a comprehensive preventative health management plan.

The post-arrival health assessment for refugees and other humanitarian entrants is funded by Medicare once within the first 12 months of arrival or residency in Australia. Clients from refugee backgrounds who are not eligible for these Medicare Item numbers may still benefit from a comprehensive health assessment, particularly if their contact with the health system has been ad hoc. Practice and refugee health nurses provide invaluable assistance in many parts of the health assessment process.

Information on MBS Items 701, 703, 705 and 707 for the Health Assessment for refugees and other humanitarian entrants is available from the Department of Health website www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_refugees.

PRACTICE TIP

If the client has immediate health concerns, these should be given priority, and the health assessment completed later, over several visits if needed. Psychological and sexual health assessment can also be delayed, as it may be more effective after trust has been developed.

RESOURCES

Community and refugee health services in many states and territories have developed their own guidance notes and or downloadable proformas for performing the refugee health assessment. Some are available online, such as the following:

- Victoria – General Practice Victoria (GPV) has developed an RACGP approved template for the Refugee Health Assessment. The template is available to download as a PDF, or can be imported into your medical software (e.g. Medical Director). Information is available on the General Practice Victoria website: www.gpv.org.au/resources.asp?cat=17.
- South Australia – The Government of South Australia's 'Migrant health Service Policies and Clinical Procedures' are available from the South Australia Refugee Health Network . The form details tests that should be considered. yooyahcloud.com/SARHN/JUupjc/HealthAssessRefugeeTemplate2010.pdf.
- ACT Clinical Guidelines are available by contacting Companion House. www.companionhouse.org.au/cms/.
- Jill Benson's work on the early health assessment of refugees in Australia was published in Australian Family Physician: digital.library.adelaide.edu.au/dspace/bitstream/2440/44587/1/hdl_44587.pdf.

PRACTICE TIP

Recommend health assessments to all new arrivals, as they may be unaware of the need for this, believing that health screening conducted prior to their arrival served this purpose.

"

"My children are being put back on track into Australian society's health system."

— Sudanese father describing his family's experience of health assessments[9]

Taking a history from your client will be assisted if health practitioners:

- use an on-site interpreter of appropriate language (and gender) wherever possible, otherwise use a telephone interpreter via the free Doctors' Priority Line (Ph 1300 131 450): www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/free-services.htm. See Section 2 for TIS registration details
- use the first appointment as an opportunity to get to know the client and their family and, explain the role of the service and preventative health care
- allow for extra time; this may require rebooking the client, if you are unaware in advance that the client is a recently arrived refugee
- request the client's case manager or sponsor, local refugee health nurse or practice staff to assist the client to attend follow-up appointments and/or referrals for investigations and other services.[12] (See Section 9 > Strategies for supporting new arrivals to access health services, p.293.)
- understand that details such as dates of birth, and names on immigration forms may be incorrect, but attempt to ensure accuracy.

General information

It is useful to collect the patient's general information, especially their preferred language and the name of their preferred interpreter in the first instance. This will act as a reminder for all future appointments.

Migration/social history

Knowledge of the client's migration history, personal background and social history is particularly important in understanding each refugee patient's health context.[10]

Migration history includes: establishing the client's background including preferred language, migration status, date of arrival, country of origin, secondary/host countries, refugee camps, detention centres.

Personal background and social history includes: current household composition, social supports in Australia, significant family members overseas or missing, and current occupation. This may also include asking about current stressors such as settlement problems, previous occupation and educational background.

This is useful because it:

- orientates your care to the client's particular needs (e.g. language, cultural, gender and religious beliefs)
- gives perspective on region specific medical problems
- alerts you to prior healthcare access and experiences, and the possibility of undiagnosed or untreated conditions
- identifies clients who are likely to have experienced significant trauma and psychological sequelae (e.g. extended periods in refugee camps, detention centres)
- identifies settlement needs and supports that may be required. (See Section 9, p.293)

PRACTICE TIP

Ongoing settlement stressors (e.g. housing, financial stress, family separation) often have a more significant impact on current mental health than previous trauma.[11] Assisting the client to link with their community and housing, settlement and other services may provide significant support.

Medical history

Taking a history from and examining a refugee client involves the same skills as those involved in the care of any new client. However, an approach that delves beyond the presenting issue, while avoiding being overly authoritarian or intrusive, is the most effective. A suggested approach is to elicit information gradually and opportunistically, often over the course of a number of consultations. Systematically working through a set of questions may be inappropriate when working with a refugee client, particularly if they are experiencing the anxiety commonly associated with a trauma reaction.

Things to consider in history taking include the following:

- Address presenting complaints first rather than the comprehensive assessment, although these are unlikely to be the only concern, other issues may not be raised spontaneously.
- In the medical history, consider illness according to country of origin,[12] such as malaria, tuberculosis, malnutrition, war-related injuries and significant previous illness as indicated by hospitalisation or operations.
- Previous chronic disease such as hypertension, COPD or diabetes may have become more serious due to delayed diagnosis, suboptimal treatment or poor nutrition and housing.
- Family history may be unknown.
- A history of tuberculosis contacts is important to obtain but may not be given accurately until trust is built with the health care provider.
- Drug and alcohol history may include traditional practices such as kava or khat. See Section 4 > Substance abuse (p.96).
- When reviewing current medications consider contact with other health care providers and traditional and herbal medicines. See Section 7 > Complementary therapies (p.276).
- Allergies may be unknown due to lack of previous medication use.
- Nutritional history should include types and amounts of food and drinks in Australia and any difficulties with Australian food. It may also include enquiry into past experiences of food scarcity. See Section 4 > Nutrition (p.104) and Section 5 > Nutritional issues (p.192).

Although many problems in refugees are similar to those of the general Australian population, additional diagnoses to consider in refugee clients are listed in Table 6.2.

Immunisation

See also Section 4 > Adult Health > Table 4.5 (p.158) and Section 5 > Children and adolescents > Table 5.3 (p.189).

Routine immunisation in the country of origin or transit may have been unavailable, interrupted due to flight or war, or rendered inactive due to poor storage of vaccinations. If there is no satisfactory history or documentation of immunisation, commence catch-up schedule as recommended by the Australian Immunisation Guidelines specific to refugees are available on the Immunise Australian website: www.immunise.health.gov.au.

The Quick Guide Catch-Up Immunisation has been developed for Victorian immunisation providers to create a catch-up immunisation schedule for those presenting without an immunisation history. See Quick Guide Catch-up Immunisation for Victoria: www.health.vic.gov.au/immunisation/general/quick-guide-catch-up-immunisation.

RESOURCES

Immunisation schedules by country of origin are available on the World Health Organization website: WHO/UNICEF review of national immunisation coverage, 1980–2005: www.who.int/immunization_monitoring/en.

PRACTICE TIP

Fee-free translation of medical documents

If a client has medical documents in languages other than English, such as vaccination certificates or medical reports, they can lodge them at their Adult Migrant English Program (AMEP) service provider outlets, which will then dispatch them to a translation service provider. The translation service will provide translation into English in the form of an extract or summary. This service is free to Australian citizens or permanent residents within 2 years of their arrival or grant of permanent residence.

For information on eligible persons and eligible documents see the Department of Immigration and Citizenship web page 'Help with Translations' where you will also find a list of AMEP providers: www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/translation_help.htm.

TABLE 6.2 Diagnoses to consider in refugee clients in Australia: A syndromic approach [15, 12, 13]

Significant symptoms	Important diagnoses to consider in refugee clients
Fever	Malaria, influenza, tuberculosis – pulmonary or extra-pulmonary, filariasis, HIV, salmonella typhi, rickettsial disease, dengue, hepatitis, dental infections, rheumatic fever, PID, pyogenic abscess, osteomyelitis and other bacterial infections, yellow fever/haemorrhagic fever (if <2/52) in Australia.
Jaundice	Hepatitis A/B/C/E/other, malaria, typhoid sepsis, leptospirosis, liver abscess or other liver or gall bladder disease, haemolysis, drug induced (e.g. isoniazid, alcohol)
Tiredness/weakness	Anaemia, iron deficiency, pregnancy, depression/anxiety/PTSD, thyroid disease, diabetes, HIV, TB, vitamin D deficiency, lead poisoning
Appetite loss	Intestinal parasites, constipation, depression/anxiety/PTSD, H. pylori, chronic disease, malignancy
Weight loss	TB, HIV , malignancy, thyroid disease, diabetes, infective endocarditis or other chronic infection, food insecurity, depression/anxiety/PTSD, bereavement, eating disorders, dental problems, intestinal parasites
Abdominal pain	Peptic ulcer/gastritis/H. Pylori infection, constipation, parasitic infestations, PID, malignancy
Diarrhoea	Giardia, amoebiasis, bacterial infection such as salmonella, shigella, cholera, campylobacter, intestinal parasites, HIV
Breathing difficulties	Asthma, COPD, tuberculosis, pneumonia. Other lung disease such as pulmonary eosinophilia, obesity, rheumatic and other heart disease, anxiety, anaemia
Cough	Acute respiratory tract infection, tuberculosis, asthma, COPD, rheumatic heart disease, bronchiectasis, reflux, medications
Muscular/joint/chronic pain	Vitamin D deficiency, injuries, muscle strain, osteoarthritis and other types of arthritis, infectious diseases (e.g. rheumatic fever, TB, osteomyelitis, sickle cell crisis, psychosomatic illness, congenital abnormalities)
Headache	Meningitis, tension headache, hypertension, depression/anxiety/PTSD, refractory errors of the eye and other eye disorders, cervical spine dysfunction, thyroid disease, sinusitis, previous head injury, migraine, infections, raised intracranial pressure, anaemia
Dysuria/haematuria	UTI, schistosomiasis, gonorrhoea, chlamydia. herpes, tuberculosis, prostatitis, bladder carcinoma
Fits, faints, funny turns	Anaemia, epilepsy, postural hypotension (due to inadequate fluid intake, alcohol and other substance use), diabetes, pregnancy, culture bound syndromes, panic attacks, anxiety/depression/PTSD
Paraesthesia	Diabetes, nutritional deficiency, leprosy, syphilis, B12 deficiency; other causes of peripheral neuropathy
Altered mental state	Acute sepsis, cerebral malaria, meningitis, encephalitis, CNS disease, diabetes, B12 deficiency; lead poisoning, drugs, psychosis.

Paediatric screening

There are currently a high proportion of children and adolescents entering Australia under the Australian Refugee and Humanitarian Program. This requires health practitioners to take a paediatric focus in relation to screening, health issues and preventative health care. For detailed information on paediatrics and screening, see Section 5.

Obstetric/gynaecology history

It is important to check if women of child-bearing age are planning or are currently pregnant or breastfeeding, and if family planning is wanted. Some care needs to be exercised in raising issues about family planning and gynaecological symptoms, and to ensure the client is comfortable with other family members or interpreters if they are present. It may be necessary to delay discussion until a female interpreter is available. Further information on women's health, see Section 4 > Women's health concerns.

Sexual health

Detailed information on sexual health concerns for adults can be found in Section 4, and for children and young people in Section 5 of this guide.

Approach to sexually transmitted infection (STI) screening

Non-invasive screening for STIs is recommended for all those who have been sexually active in the past, including suspected victims of sexual assault. It is advisable to discuss screening confidentially and separate from other family members. Adolescents should be routinely offered screening for STIs. This may be more acceptable if a detailed sexual history is omitted initially.[14]

Presenting these investigations as a routine part of a comprehensive health assessment will help to restore the client's confidence in their own health and bodily integrity, and allow them to consider future sexual relationships or child-bearing without the fear of an STI. See also Section 4 > STIs (p.152).

A GP was interviewing a newly arrived African family consisting of mother, father and two adolescent children. The GP noted that the husband seemed relaxed and expansive, while the wife seemed quiet and withdrawn. While the husband and children were being assessed by the practice nurse, the wife was given the opportunity to speak privately about her concerns. She immediately volunteered that she had been a victim of domestic violence during all of her marriage, apart from when her family was in the refugee camp, where her husband left her alone because he took a second wife. She was afraid the abuse would start again, and requested a separate house for herself and her 2 children, and gratefully accepted the offer of STI screening.

Mental health/psychological screening

In addition to taking a history and conducting a medical examination of a client from a refugee background, it is important to conduct psychological assessment, as this will provide important information to assist in:

- developing a plan to address both physical and psychological health concerns
- anticipating the degree of trauma to which the client is likely to have been exposed as well as the likelihood of settlement stress
- identifying the need for referrals for psychiatric or psychological support or treatment
- understanding the likely impact of the psychological state on the physical health problems.

PRACTICE TIP

Psychological screening may be delayed until acute medical issues have been managed and rapport has been developed with the client. It is recommended to review this part of the history without other family members present.

Important symptoms to screen for include:

SOMATIC

- appetite
- energy levels
- sleep disturbance
- daily activities
- aches and pains

PSYCHOLOGICAL

- memory
- concentration
- mood/affect
- 'big worries' (may elicit ruminations, intrusive memories; settlement stressors, concern for family overseas, psychosis, etc.)
- plans and hopes for the future.

Take note of your client's interest in sharing their psychological concerns. It may indicate the appropriateness of offering referral for psychological support.[15] Also consider your capacity to respond, including your role, the time available to you and your interest and expertise in refugee health.

"I told this lady, I told her to go to the doctors and she said, 'They waste your time, they sit in front of you and make you talk, talk, talk.' I don't want to talk for a long time. I just don't feel like talking to no-one."

– Somali woman (32)

Trauma history

(See also Section 3)

It is not necessary to ascertain specific details of traumatic experiences. The knowledge that the client has endured certain events due to their country of origin or transit (e.g. detention, violence) is generally sufficient for care planning.

Consider asking about past trauma only if appropriate and there is adequate time for a response. Chronic or regional pain presentations may be symptoms of past trauma or psychological distress.

Some useful questions are:

- Some people have had bad things happen to themselves and their families. Has anything happened to you or your family that could be affecting your health or the way you are feeling now?
- Do you have any problem I can help you with today that is a result of something that happened in the past?

PRACTICE TIP

Referral forms and information about torture and trauma counselling services in your state or territory can be obtained by contacting the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) agency in your state or territory: www.fasstt.org.au

Physical examination

A full physical examination is an essential part of the health assessment. Important components including signs and diagnoses to consider are included in Table 6.3.

TABLE 6.3 Recommended physical examination of refugee clients

Physical examination	Sign	Diagnosis to consider in refugee clients and notes
Height/weight, percentiles/BMI	Low BMI/percentile	Malnutrition/ chronic infection (e.g. parasites, tuberculosis, depression, obesity/Western-style diet). See Table 6.2 (p.243). Repeated measurements useful especially in children
	High BMI/percentile	Obesity
BP	Hypertension	May be chronic and undiagnosed, or secondary to anxiety
	Hypotension	Poor fluid intake/excessive coffee intake
Temperature	Fever	Correlate with length of time since arrival, recent country resided in and other symptoms and signs (e.g. cough, rash). See Table 6.2.
Peripheries/skin	Scarring	Torture, trauma, burns, keloid, BCG scar[110]
	Rash	Fungal infections, scabies, cutaneous larva migrans, other creeping eruption
	Itch	Dry skin, eczema, scabies, onchocerciasis, psychogenic
	Altered pigmentation	With anhidrosis/anaesthesia: leprosy
	Hair loss	Fungal infections, psoriasis
	Nail changes	Onychomycosis, koilonychia (prolonged Fe deficiency)
	Spider naevi	Liver disease, B12 deficiency, pregnancy
	Ulcers	Cutaneous leishmaniasis, bacterial, tropical
	Oedema	Lymphoedema – filariasis
Eyes	Jaundice, anaemia Pterigia, cataracts	See Table 6.2 (p.243)
	Xeropthalmia Squint Refractive error	Vitamin A deficiency dryness and ulceration
	Lid scarring	Trachoma scarring, nodules (like sugar crystals under upper lid)
Ears	Discharge Perforation	Chronic suppurative otitis media
	Deafness	Chronic infection, traumatic (head injury/explosions)
Dental	Dental caries	
	Missing teeth	Torture trauma, cultural practices
	Gum disease	Gingivitis/ vitamin C deficiency

TABLE 6.3 Recommended physical examination of refugee clients (continued)

Physical examination	Sign	Diagnosis to consider in refugee clients and notes
Neck	Goitre	Iodine deficiency/hypo/hyperthyroidism
	Lymphadenopathy	See below
Lungs	Localised crepitations Generalised crepitations	Bronchitis/bronchiectasis, pneumonia Congestive cardiac failure (may be secondary to rheumatic/ischaemic heart disease, anaemia)
	Cavitations/pleural effusions	Tuberculosis
	Wheezing	Pulmonary eosinophilia, asthma
Heart	Heart murmurs Pericarditis	Rheumatic heart disease, undiagnosed congenital heart disease, flow murmur from anaemia, tuberculosis, hypertensive cardiomegaly
Abdominal	Hepatomegaly and/or tenderness	Hepatitis (viral, alcohol, other), schistosomiasis, thalassaemia, amoebic or pyogenic liver abscess, hydatid, hepatic carcinoma, subphrenic abscess, visceral leishmaniasis, chronic liver disease, malaria
	Splenomegaly	Typhoid, malaria (with hepatomegaly), visceral leishmaniasis, thalessaemia, bacterial endocarditis, liver disease
Lymph nodes	Generalised lymphadenopathy	Tuberculosis, HIV, toxoplasmosis, lymphoma
	Localised lymphadenopathy	Tuberculosis, lymphogranulosum venereum, Lymphoma or other malignancy, toxoplasmosis, chancroid
If symptomatic or at a later date review the following systems:		
Skeletal/muscular	Bone deformity Joint disease. Chronic bone pain and tenderness	Old fractures – may be malunited, or other trauma, vitamin D deficiency Osteoarthritis, tuberculosis, inflammatory arthropathy, tuberculous osteomyelitis
Male genitalia		Urethritis, filariasis, epididymitis
Female genitalia	Pelvic tenderness: Vulval scarring, fistulae	Chronic PID, previous endometritis, female genital mutilation
CNS and PNS	Hyper-reflexia: Decreased sensation Weakness	Thyroid disease, anxiety Diabetes, with thickened peripheral nerves-leprosy, B12 deficiency Malignancy or other space occupying lesion, lead poisoning
Urinalysis	Red cells, white cells	Infection (e.g. UTI, STI, schistosomiasis) undiagnosed renal disease
	Protein	Renal disease, diabetes
	Glucose	Diabetes

Undertaking investigations

Screening investigations suggested for refugees coming from resource-poor countries are summarised here. More may be needed depending on the client's symptoms, country of origin and transit. Chronic and nutritional disease screening is essential, as they are more common than infectious disease in most communities. Informed consent is important prior to screening.

Routine tests recommended by Australasian Society for Infectious Diseases (ASID) are:[16]

- Mantoux or interferon gamma assay, e.g. quantiferon gold test (validated if >18, Medicare rebate if immunocompromised)
- hepatitis B serology : specifically request Hep B sAb/sAg/cAb
- hepatitis CAb
- HIV
- syphilis RPR/TPPA
- malaria Plasmodium falciparum antigen and thick and thin film FBE and if available faeces microscopy
- schistosomiasis IgM/IgG
- Strongyloides serology
- stool COP if readily available or abdominal symptoms
- if upper abdominal symptoms, helicobacter stool antigen or urease breath test for H. Pylori
- STI screen if previously sexually active including:
- first-pass urine PCR for chlamydia and gonorrhoea (or urethral or cervical swabs)

Non-infectious screening for refugees includes:

- ferritin
- vitamin D level (if dark skinned or other risk factor). See Section 4 (p.110) and Section 5 (p.195).
- B12 especially in Bhutanese, Nepalese and Tibetan refugees
- for women of child-bearing age, include haemoglobin electrophoresis, Rubella Ab, MSU, consider varicella Ab
- vitamin A level if <15 years (WHO advocates empirical treatment for risk groups). See Section 5 > Vitamin A (p.194).

See also Section 5 > Suggested initial investigations (p.182) for screening children.

RACGP screening for chronic disease and cancer screening is also recommended according to age and gender (e.g. Pap, mammography, fasting lipids and glucose).[17] The health assessment is an ideal time to introduce regular chronic disease screening.

Investigation results

It is essential that patients are adequately informed about test results and followed up if they do not attend their review appointments. The knowledge that their tests are normal may give people of refugee background enormous relief. Positive tests of unfamiliar diseases and any further investigations and treatments often need detailed and repeated explanations with a professional interpreter. See Section 2 > Cross cultural communication (p.31) for more information.

Table 6.4 provides information about common investigation results. Further information about common diseases and their management can be found in Section 4 (p.79).

The Communicable Disease Australia website provides links to Australian state and territory health departments and Australian and International communicable diseases and health agencies: www.health.gov.au/internet/main/publishing.nsf/content/cda-cdilinks.htm.

Treatment guidelines for the following common infectious disease have been developed by ASID and are available on this link: www.asid.net.au/downloads/RefugeeGuidelines.pdf.

- malaria
- intestinal helminthes
- tuberculosis
- blood borne viruses
- other infections
- Helicobacter pylori
- sexually transmitted infections
- schistosomiasis.

TABLE 6.4 An approach to common investigation results

Test/result	Differential diagnosis	Initial management
FBE/microcytic anaemia	Iron-deficiency anaemia, thalessaemia. See p.118	Treat iron-deficiency anaemia and recheck FBE, Fe studies +/– haemoglobin electrophoresis, after 3 months
Fe/studies	Fe deficiency, low ferritin, low serum iron, increased TIBC	Investigate and treat cause of anaemia, rule out hookworm infection.
		If dietary cause, educate about iron-rich diet, 3 months of iron treatment, then repeat bloods, if not resolving, investigate further.[18]
FBE/eosinophilia	Worms, e.g. strongyloides, hookworm, schistosoma, filariasis, hydatid disease, cysticercosis, cutaneous larva migrans, tropical pulmonary eosinophilia	See Section 4 (p.126). Further investigations for type of parasite, if not resolving after treatment refer to infectious diseases.
Faecal specimens/OCP	Pathogenic	Entamoeba histolytica Ascaris lumbricoides Giardia intestinalis Hookworm (Ancylostoma or Necator) Tapeworm (Taenia spp) Whipworm (Trichuris spp) See Section 4 and antibiotic guidelines for treatment
	Non-pathogenic	Entamoeba coli Entamoeba hartmanii Entamoeba gingivalis Endolimax nana Iodamoeba butschlii Blastocystis hominis (may be symptomatic) Dientamoeba fragilis (may be symptomatic)
Vitamin D level <50	<12.5 severe insufficiency 12.5–25 Vit D moderate deficiency 25–50 Vit D insufficient	Treat with daily 1,000-2,000 IU D3 or high-dose vitamin D if available. Retest after 3 months, then 12 monthly[19] screen family members. See Section 4 (p.110)

Continued next page

TABLE 6.4 An approach to common investigation results (continued)

Test/result	Differential diagnosis	Initial management
HBV sAg +ve HBV cAb +ve HBV sAb +ve	Current infection (acute/chronic) Current or past infection Immune (vaccinated or resolved infection)	If s Ag +ve or sAb –ve and cAb +ve needs LFTs, full Hep A/B/C serology, HBV viral load, alpha-fetoprotein, INR, ultrasound If abN LFTs, or Hep B e Ag +ve refer Screen family members and vaccinate if non-immune
Hep C Ab +ve	Hepatitis C past or present infection	Check Hep C viral RNA, LFTs, If either abnormal refer
Schistosoma Abs	Past or present infection	If +ve titre, check stool and end urine for schistosoma eggs and blood, and FBC for eosinophilia. See Section 4 > Infectious diseases or the ASID guidelines, for treatment.
Mantoux test	See p.203 for interpretation of Mantoux	CXR and screen family members if +ve Mantoux or gamma IFN +ve
Gamma interferon. e.g. quantiferon gold	Likely to be past infection	CXR and screen family members if +ve Mantoux or gamma IFN +ve If <35 refer infectious diseases for treatment If >35 physical exam and CXR, refer or review CXR and physical yearly for signs of TB Screen family members if +ve.
Syphilis results TPHA, RPR	See Section 4 (p.152)	See Antibiotic Guidelines for treatment.
Strongyloides Ab	Past or present infection See Section 4 (p.147)	Check eosinophil count and stool specimen. See Section 4 on strongyloides, and ASID guidelines for treatment. Follow up at 6 months and 12 months with serology and eosinophil count.
Malaria ICT +ve or thick and thin film +ve	Treat for malaria	Review urgently if P. falciparum, febrile or acutely unwell Refer ID for advice and see Antibiotic or ASID Guidelines for treatment.
Urease breath test/stool antigen for H. Pylori	See Section 4 (p.155)	See Antibiotic Guidelines for H. pylori treatment Retest after 4 weeks if persistent symptoms to check eradication.

Assessment of client

It is useful to list all of the diagnoses and problems from the history, examination and investigations in order of urgency. It forms the basis of the management plan.

Management plan

A management plan includes:

- initial treatment plans including prescriptions, diet and lifestyle advice
- initial immunisations
- further investigations
- referrals to allied health professionals, approved torture and trauma professionals and/or specialist clinics
- arranging review for other issues found in the list of diagnoses and problems
- Pap smears, mammography, STI screening, and consideration of contraception advice, if not already performed.

PRACTICE TIP

Patients should be offered a copy of their management plan which should include investigation results. This forms a useful hand-held record to show other health providers.

Chronic disease and health management items can also be organised at a later date if these conditions are uncovered using the following MBS Items:

- Multidisciplinary Case Conferences by Medical Practitioners (Other Than Specialist or Consultant Physician) – (Items 735, 739, 743, 747, 750)
- Case Conferences by Consultant Physician – (Items 820, 822, 823, 825, 826, 828, 830, 832, 834, 835, 837, 838)
- Medication Management Reviews – (Items 900 and 903)
- A mental health assessment and plan can also be done to facilitate appropriate referral for further mental health care. (Items 2700, 2701, 2712, 2713)

References

1. Department of Immigration and Citizenship. (2006). Health Screening Protocols for Refugee and Special Humanitarian Entrants to Australia from East and West Africa. Version 1.4. Canberra: DIAC, Humanitarian Business Process Section.
2. DIAC. (2010). The Health Requirement – Fact Sheet 22. Canberra: DIAC. Retrieved from < www.immi.gov.au/media/fact-sheets/22health.htm >.
3. DIAC. (2011). Assistance for Asylum Seekers in Australia – Fact Sheet 62. Canberra: DIAC. Retrieved from < www.immi.gov.au/media/fact-sheets/62assistance.htm >.
4. Davidson, N., Skull, S., Chaney, G., Frydenberg, A., Isaacs, D., Kelly, P...Bugner, D. (2004). 'Comprehensive health assessment for newly arrived refugee children in Australia'. Journal of Paediatric Child Health, 40(9–10), 562–8.
5. Ngeow, J., Skull, S. & Biggs, B. (2001). 'Assessment of the Health and Vaccination Status of Recently Arrived Immigrants in Australia'. Africa[n] Community Health Project Victorian Infectious Diseases Service and the Department of Medicine, University of Melbourne (Unpublished paper)
6. Hale, K., Wood, N. & Sheikh-Mohammed, M. (2006). 'Camp to clinic: A refugee journey'. Medical Journal of Australia, 185(11/12), 589–90.
7. Tiong, ACD., Patel, MS., Gardiner, J., Ryan, R., Linton, KS, Scopel, J. & Bigg, B-A. (2006). 'Health issues in newly arrived African refugees attending general practice clinics in Melbourne'. Medical Journal of Australia, Dec 4-18, 185(11/12), 602-606.
8. Ackerman, L.K. (1997). 'Health problems of refugees'. Journal of the American Board of Family Practice, 10(5), 337–48.
9. Walker, K. (2005). I Would Rather They Tell Me': Sudanese Refugees' Experiences of Health Assessments: A Pilot Study. Victoria: Department of General Practice, Monash University.
10. Adams, K.M., Gardiner, L.D., & Assefi, N. (2004). 'Healthcare challenges from the developing world: postimmigration refugee medicine'. British Medical Journal, 328, 1548–1552.
11. Schweitzer, R., Melville, F., Steel, Z. & Lacherez, P. (2006). 'Trauma and post migration living difficulties as predictors of psychological adjustment in resettled Sudanese refugees'. Australian and New Zealand Journal of Psychiatry, 40, 179–187.
12. Fairley, C., Hocking, J., Gunn, J., Parker, R., & Pavlin, N. (2006). 'Implementing Chlamydia Screening: attitudes of General Practitioners and young women Public Health Research Report'. University of Melbourne (unpublished).
13. Murtagh, J. (2011). General Practice (5th edn). Australia: McGraw-Hill Medical Publishing.
14. Fairley, C., Hocking, J., Gunn, J., Parker, R., & Pavlin, N. (2006). 'Implementing Chlamydia Screening: attitudes of General Practitioners and young women Public Health Research Report'. University of Melbourne (unpublished).
15. Bailes, M. (2005). 'Mental Illness and Help-Seeking Concepts and Attitudes in the Somali Community in Melbourne'. Masters Thesis. Melbourne: University of Melbourne.
16. Australasian Society for Infectious Disease (2009). Diagnosis, Management and Prevention of Infections in recently arrived refugees. Sydney: Dreamweaver Publishing. Retrieved from: < www.asid.net.au/downloads/RefugeeGuidelines.pdf>.
17. The Royal Australian College of General Practitioners (RACGP). (2009). Guidelines for preventive activities in general practice (7th edn). South Melbourne: The Royal Australian College of General Practitioners. Retrieved from < www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/TheRedBook/redbook_7th_edition_May_2009.pdf >.
18. Centre for Disease Control and Prevention. (2010). Refugee Health Guidelines: Lead Screening. Retrieved from < www.cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html >.
19. Victorian Department of Health. (2011). Low Vitamin D in Victoria: Key Health Messages for Doctors, Nurses and Allied Health. Retrieved from: < www.health.vic.gov.au/chiefhealthofficer/publications/low_vitamin_d_med.htm >.

Section 7:
Consultation and management – special issues





As indicated in Section 6 > Refugee health assessment(p.227), the healthcare consultation can, if sensitively conducted, make a significant contribution to psychological recovery. People from refugee backgrounds share many client care needs in common with other patients. However, they also have additional needs resulting from their past experience of health care, exposure to traumatic experiences prior to arrival and language and cultural differences. The outcomes of health consultation can be compromised if steps are not taken to accommodate these concerns.

This section identifies some approaches which can be adopted by clinical service providers caring for people from refugee backgrounds to optimise consultation and ongoing management.

In Section 8>Strategies for supporting new arrivals to access health services some service and practice level strategies that can be adopted to streamline care of refugee clients are outlined.

Arranging appointments

Initial appointments

As the appointment system may be unfamiliar to many clients consider:

- arranging an interpreter, if required
- explaining the appointment system to clients who are unaccustomed to making appointments
- making reminder calls about appointments, in the language of the client
- avoiding early morning appointments as sleeping problems are common among traumatised clients, or clients may be unfamiliar with public transport
- encouraging the client to consider an overall health assessment
- becoming familiar with Medicare items to use for refugee care (see Medicare Items, p.268).
- encouraging reception staff to explain to refugee clients if an appointment is delayed (e.g. explaining the cause and the likely length of the wait)
- before the next appointment, familiarising yourself with the background and likely health problems of the client.

> "We the Sudanese, we have problem with time. When you come very late you are just sitting there and those people will just tell you, you have come late so you just have to stay there by the people who are very concerned by the time."
>
> — Sudanese client[1]

Follow-up appointments

Where care will need to take place over several consultations, plan these in advance so that an interpreter can be arranged. Longer appointments will be required to accommodate the additional time taken to communicate through an interpreter. See Section 2 > The importance of using a professional interpreter (p.32).

Where possible, allow some flexibility as refugee clients may experience difficulties in maintaining follow-up appointments. This may be due to transport difficulties, memory problems, anxiety or even fear and mistrust of health professionals.

Consider a reminder call to refugee clients prior to the appointment (in client's preferred language if possible), particularly in the early stages of resettlement, or liaison with their case worker or sponsor.

> "Someone always rings to tell her about her appointments so she is happy with the service."
>
> — Sudanese client[1]

Management goals

When setting management goals it is important to keep in mind short term as well as long-term outcomes. At the beginning of Section 4 > Adult health and Section 5 > Child and adolescent health you will find a diagram of longitudinal health outcomes (Figure 4.1 and Figure 5.1) that should be kept in mind when writing a management plan with your patient. The diagram is devised to show where patients should be in the health system in ten years time: oriented within the system and accessing a full range of preventative and ongoing health services.

While working with the client, it is important to set small achievable goals. Be prepared that progress might be slow and that you may need to repeat instructions several times in the course of your consultations with the client.

Prioritise the client's health concerns in consultation with them and address them over several sessions. Deal with problems which are serious and which are worrying the client first.

Where management involves the client adopting lifestyle or behavioural changes, it is important to set goals that accommodate the client's coping style and, if relevant, cultural practices.

> "Back in Sudan they only take a small amount of blood, blood tests are not well known. In Sudan they use the blood for other things. They give the blood away or sell it without permission. The doctors or nurses may have an agreement with someone that the blood be used for other purposes."
>
> — Sudanese client[1]

KEY POINTS

Explaining procedures and investigations

- When deciding whether to proceed with or defer an invasive procedure, establish rapport with the client and ensure that they fully understand the procedure and the reasons for performing it.
- Consider that some clients may wish to involve other family or community members in healthcare decision-making.
- Male healthcare practitioners should consider offering female clients referral to a female practitioner, particularly if investigation or treatment of gynaecological problems is required. Male clients may also be more comfortable with a male healthcare practitioner.
- Awareness of the stigma attached to certain diseases (e.g. tuberculosis) will enable a sensitive approach to investigation and ongoing care.
- It is important to take adequate time and possibly, several explanations if needed, of the results of investigations or procedures. Some clients with chronic conditions have difficulty understanding that a negative result does not imply absence of pain/illness or malingering. See Section 4 > Chronic pain (p.166).

“I didn’t understand what it was for. I wasn’t told specifically what it was for. If I come for a check up I would rather they tell me first that I am going to be checked for these diseases so that when I come back for the results I’ll know what questions to ask.”

— Sudanese client[1]

Explaining privacy and confidentiality

It is helpful, at an early stage of the consultation, to reassure the client about the privacy and confidentiality of their medical records. Refugees or asylum seekers who are survivors of interrogation or torture may be especially concerned, as they may find the history taking process very threatening.

The professional roles of interpreters also need to be explained to clients. Interpreters adhere to the National Accreditation Authority for Translators and Interpreters (NAATI) www.naati.com.au code of ethics. The client will be reassured if the health professional does two things: treats the professional interpreter as a respected colleague yet; assumes and maintains clear but respectful control of the consultation.

For small and emerging communities, it may not be possible to get fully qualified professional interpreters, and indeed the interpreter may be of that small community and well known to the client. It is useful to check that the client is comfortable with the chosen interpreter. Alternatively, use the Doctors Priority Line (1300 131 450) interpreting service to obtain an interstate interpreter, giving only the first name of the client.

Responding to the impact of psychological effects on the consultation

Consultation with a client who has a trauma and torture history may be optimised by:

- using a professional interpreter and explaining their role
- explaining to the client that procedures can be suspended and rescheduled for another day if they become overly anxious
- establishing trust by being particularly vigilant in the exercise of confidentiality and in obtaining consent for all procedures
- giving clients as much choice and control as possible
- avoiding inquisitorial questioning, (such as a detailed systems review), since this may reinforce a sense of powerlessness and trigger memories of past interrogations
- anticipating reactions of fear, anxiety mistrust and even hostility as possible responses to trauma
- being aware that the surgery and aspects of the consultation may be reminders of past trauma (e.g. being made to wait, sudden movements, seating arrangements, medical instruments)
- anxiety can also be reduced by carefully planning the client's management in consultation with the client
- guilt may undermine a survivor's capacity to follow through instructions which involve 'self-care'.

Depression and a lack of self-worth may affect the motivation required to follow through on instructions.

The client's means of dealing with anxiety and depression may interfere with their capacity to adopt health promoting practices. For example, excessive tobacco consumption appears to be common among some refugees and is perceived as a means of dealing with anxiety and depression. In these circumstances particular sensitivity may need to be exercised and goals set that accommodate clients' circumstances.

Specific instructions may be impossible to adhere to because they invoke memories of torture. For example, the fact that food was used as an instrument of torture in many regimes may have resulted in eating disorders which become barriers to healthy eating.

PRACTICE TIP

Providing clear, concise information and promoting client control and choice go a long way towards assisting refugee clients to gain confidence. In working with severely traumatised clients a number of additional factors may need to be considered.

See Section 3 (p.45) for more detailed information on psychosocial assessment.

Hospitalisation and the refugee client

Most refugee clients cope with hospitalisation without any difficulties. However, for some clients certain aspects of the hospital experience can be extremely alienating and threatening, even for those clients without a reported trauma history.

TABLE 7.1 Hospitalisation and the refugee client

Concerns	Ways to minimise client distress and hospital staff frustration
Large teaching/grand ward rounds may be very threatening to some refugee clients especially those from rural backgrounds	Where possible avoid intimidating numbers of staff (particularly surrounding the patient's bed)
Frequent room changes and bed changes can remind people of their flight experience	Try to minimise relocations as much as possible
Frequent blood tests	Try to limit investigations
Different anatomical understandings/models of disease	Explain procedures and explain educational materials
Frequent changing of nurses/ doctors leading to inconsistency of information (perceived/actual)	Consider possibilities for consistent care and/or one 'medical representative' to enable rapport and trust
Designate one person as the one who conveys information to the client.	
Client difficulties making major health decisions and feeling overwhelmed	Close liaison with GP/Refugee health nurse/case worker
Be prepared to repeat information, particularly if the client appears confused	
Lack of appropriate educational materials	Develop educational materials for clients with low literacy. See Section 10 (p.316).
Lack of, or inconsistent use of, interpreters	Use hospital-based or contracted interpreters

"There is a problem with having so many checkups you know. It causes stress because if the doctor sends you to check up more than three times and they keep saying we don't know what the problem is, that will make you suspicious. Maybe they're hiding something or they find something in your body but they don't want to tell you and they want to know more so that's a bit of stress and anxiety."

— Sudanese client[1]

The team approach to refugee health in primary care

Consider who is in your team: reception, practice nurse, doctor, practice or health centre management. What roles do each have in client care and how might this apply in the health assessment and care of refugee clients?

It is useful to consider the demographics of the clinic area, and which particular refugee groups are being seen most frequently. This helps in the provision of targeted, language specific client education materials.

PRACTICE TIP

"At our practice, reception staff are trained and have the authority to book an interpreter for the client. Language and gender needs are specified in the front cover of the history, and on the practice software. The receptionists have been trained to book long appointments for refugees and new arrivals, who are flagged in a different colour in the appointment book. Refugee health nurses do preliminary assessments at a home visit and notify the GP of any special concerns prior to the client's first appointment. Our general practice nurses are all fully trained to give immunisations and essentially arrange this with the clients themselves, and put recalls on practice software. All the nurses in the practice can now administer and read Mantoux tests. The doctors who see refugees, and the refugee health nurses, have regular meetings to discuss protocols, procedures, share stories and support each other. We are lucky in that our practice management is very supportive of the work."

– Melbourne GP

Engaging allied health and specialists

Allied health and specialist health services are part of the team approach to healthcare. Where possible refer patients of refugee background to community health and bulk-billed allied health services (e.g. optometrists, physiotherapists, dental health centres) in your area, keeping in mind that allied health and dental practitioners are not funded by the Australian Government to engage interpreters. Making a referral to public outpatient services in your local hospital is important, as the cost of specialist services may by prohibitive for some families of refugee background.

The team approach within the community context

A team care approach extends to engaging with and being aware of local services in your area that can strengthen the overall health of people from refugee backgrounds. Your local migrant resource centre (MRC) can provide referral advice to community and family services. Table 7.2 lists some other agencies in your local area that might provide assistance and activities specifically for the refugee community groups in your local area, and in the preferred language of some clients. It may be worth compiling a contact list for these agencies.

TABLE 7.2 Agencies in your local area that might provide support or activities for people of refugee background

Local government	Health services	Family services	Community centres
Centrelink	Refugee health clinics and nurses	Counselling services	Rooms for hire
Housing services	Women's health programs	Disability services	Playgroup
English classes	Health promotion programs	Youth support	Men's sheds
Legal and migration support	Nutritional education	Education programs	Parents' groups
Employment services	Dental care promotion	Support for parents and carers	After-school care
Advocacy services	Programs for carers	Material aid	School holiday program
Youth services	Programs supporting people with disabilities	Financial counselling	Material aid
Children's services	Alcohol and drug information	Family violence services	Computer access
Family services	Sexual and reproductive health information		Community kitchens
Community development	Maternal and Child		Community gardens
Multicultural services	Health (MCH) services		Sports facilities
Libraries	Walking school bus programs		Adult education
Parks	Sexual health education		Support groups
Leisure centres (swimming pools, gyms)			Children's activities
Sports centres			Support groups
Schools			Art projects/spaces
School holiday programs			Youth programs

Adapted from Victorian Foundation for Survivors of Torture. (2011). School's in for Refugees: A Whole-School Approach to Supporting Students of Refugee Background (2nd edn), Victorian Foundation for Survivors of Torture, Melbourne.

Medicare items

There are several Medicare item numbers useful when billing refugee clients, these include:

- Health Care Card Holder Items 10900, 10901, 10992
- Refugee Health Assessments Items 701, 703, 705, 707
- GP management plan Item 721
- Coordination of team care arrangements Item 723
- Contributing to multidisciplinary care plan Item 729
- Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements Item 732
- Multidisciplinary Case Conference by Medical Practitioners (Other Than Specialist Consultant Physician) Items 735, 739
- Case Conference by Consultant Physician Items 820, 822, 823, 825, 826, 828, 830, 832, 834, 835, 837, 838
- Domiciliary medication management review (DMMR) (known as Home Medicines Review) Item 900, 903

GP Mental Health Care Items

- Preparation of a GP mental health treatment plan Items 2700, 2701
- Reviewing a GP mental healthcare plan Item 2712
- GP Mental Health care consultation Item 2713
- GP Mental Health Care Items can be used with the Medicare Chronic Disease Management (CDM) Item numbers.

Nursing and allied health Item Numbers

- Service provided by Practice Nurse 10986
- Attendance by Nurse Practitioner Items 82205, 82210, 82215
- Cervical and Vaginal Cytology (including Pap smears and Preventive checks) Items 73053, 73055, 73057

There is no Medicare item for using an interpreter when offering an allied health service. For interpreting services see Section 11 > Referral.

These item numbers are subject to constant revision. See Medicare Benefits Schedule online: www9.health.gov.au/mbs/search.cfm.

Please consider that refugee clients have limited financial supports – bulk-billing these clients is strongly recommended.

> "There is some Medicare funding for psychology services, although with private psychologists you can't get interpreters for free, so you can't use an interpreter with a private psychologist generally and there aren't any that I am aware of that speak Dari or Pashtu"[2]
>
> — client of FASSTT service

RESOURCES

Desktop companion to MBS item numbers

The Victorian Department of Health has produced a useful desktop resource about MBS Items for primary health care agencies. This resource is known as the MBS flipchart. The MBS flipchart summarises relevant MBS Item numbers for health assessments, prevention of chronic disease, care planning and case conferencing, allied health, Better Start services, Mental Health, service incentive payments, quality use of medicines, bulk-billing incentives, telehealth and Items for practice nurses. The chart was revised in December 2011. In the updated MBS flipchart, the relevant MBS item numbers, their applicability to clients and their business rules have been summarised and provide an excellent resource for all primary healthcare agencies. The flipchart is available for download and printing from the Victorian Department of Health website: http://docs.health.vic.gov.au/docs/doc/MBS-flipchart .

Prescribing issues and compliance

Factors to consider when prescribing for refugee clients

Many refugees have come from areas where they have been able to self-prescribe antibiotics and other medication. They may not be aware of the consequences of incorrect, under- or over-dosing or not completing the course of medication. Accordingly it is important that particular care is taken in giving instructions relating to dose and course.

When working with an interpreter ask them to write the dose and course instructions in the client's own language. You might also consider using pictorial diagrams to explain dosing regimens.

Prescribing may also need to take into account a client's cultural or religious practices. This is particularly the case for Muslim clients. See Health Care Providers' Handbook on Muslim Patients: www.health.qld.gov.au/multicultural/health_workers/support_tools.asp.

Cost will be a significant barrier to many refugees, so it is important to be aware of the cost of medications, and, wherever possible, to choose a Pharmaceutical Benefits Schedule listed drug or, if this is not possible, the best priced drug with equal efficacy should be prescribed.

Compliance, a problem in the general community, may be further exacerbated in refugee communities owing to the factors listed here.

Communication difficulties are common with this client group. It is best to prescribe the simplest and shortest course of treatment and to use once-daily or stat (once on the spot) dose. Explanations need to be given in the client's own language and may be supplemented with a visual aid.

Perceptions of Western-style medicine differ. People may resist accepting medications or have limited faith in their efficacy. Alternatively, they may have unrealistic expectations of immediate results.

Reduced tolerance of side effects can be a problem for survivors experiencing physical and psychological sequelae associated with torture and trauma. For example, pain resulting from medications can evoke memories of torture. Palpitations may remind the person of specific life-threatening events (e.g. a sham execution), while dryness of mouth can be a reminder of enforced thirst. There is increasing evidence of varying side effects to medications and efficacy of medications based on ethnicity. Depending on clinical need, it may be wise to commence the client on a lower dose of the medication and increase it slowly.

Consider a referral to a nurse or a Home Medicines Review for clients with complex medication regimens (e.g. tuberculosis) and experiencing difficulties with compliance. For information go to the Medicare web page on the Home Medicines Review: www.medicareaustralia.gov.au/provider/pbs/fourth-agreement/hmr.jsp.

> "When they come to the doctor and they're ill. They just want the doctor to prescribe for you, but it's a bit different here because they have to find the cause of your illness before they prescribe medication. They just think that one medication, the doctor will just detect instantly that you have this disease and just prescribe for you the medicine instantly"
>
> — Sudanese Arabic interpreter[1]

General concerns held by refugee clients

Many refugee clients will be unfamiliar with the Australian healthcare system, its culture and structure. This may affect their ability both to access the services they require and to make the best use of them. Consider taking time to provide clients with information about your role, the key features of the Australian healthcare system (such as confidentiality, costs and making appointments) and health entitlements and services available to them in Australia. For more information on these see Section 9 (p.293).

General concerns held by asylum seeker clients

Many asylum seekers living in the community (on Bridging Visas) have limited access to Centrelink and some are not eligible for Medicare. Some will be unfamiliar with the Australian healthcare system, its culture and structure. This may affect their ability both to access the services they require and to make the best use of them. Consider taking time to provide clients with information about your role and the key features of the Australian healthcare system

Concerns about health and migration status

Some new arrivals may fear that their migration status will be jeopardised if they are found to have a serious health concern. This may affect their preparedness to seek health care and to share information about their health with care providers.

A person granted permanent residence in Australia cannot be deported if, after arrival in Australia, they are found to have a significant health problem. A significant health concern detected prior to arrival does not normally affect eligibility for a humanitarian visa. However if a person is found to have given fraudulent information when applying for Australian permanent residency consideration may be given to cancelling their visa. Doctors are not legally bound to report people whom they believe have acted fraudulently. However, in rare circumstances they may be compelled to give evidence in court.

A health problem will not prejudice an application for protection lodged by an asylum seeker who has entered Australia with valid entry documentation. A condition of being granted a visa is that the applicant undergo a medical examination. The outcome of this examination does not affect eligibility, their ability to access public healthcare services once the visa has been granted, or their rights to propose immediate family members to join them in Australia.

For further advice on health-related immigration matters contact a refugee legal service in your state or territory. See Section 11 (p.323).

Practical support and access

Transport

Clarify with the client that they are familiar with the transport route to relevant services. In some instances it may be appropriate to arrange or provide transport.

Childcare

Explore whether the client requires childcare or other practical support in order to attend appointments.

Outreach and follow-up

As indicated in Section 1 (p.15), access to resources such as social connection, employment and housing are critical in promoting the health of new arrivals. However, they may experience some difficulties in accessing these resources and may not be familiar with support services and programs.

Health professionals providing clinical care have an important role in identifying and referring clients who require support with the tasks of settling in Australia. Indeed, for many new arrivals these health professionals may be their first point of contact with the Australian health and social support system. As such they are an important ‘gateway’ to other resources and supports.

For more detailed information on referring for settlement and allied health support see Section 9 (p.293) and Section 11 (p.323).

Liaison and referrals

The need for follow-up care

Given their generally poorer health status and lack of prior access to quality health care, many refugee clients may require extensive follow-up medical care. Undertaking tests and attending specialist appointments can be time consuming and involve a great deal of organisational effort on behalf of the refugee client, particularly given their lack of familiarity with the health and public transport systems. Medical tests, particularly if they are invasive or involve technology which is unfamiliar (e.g. ultrasound), may be a source of great anxiety to a traumatised client.

> "An appointment was made for me to go to the hospital. When I came there, they told me you're not supposed to come again. I showed them the booking and everything. Why should I be asked not to come? I haven't done anything why am I not supposed to come? Is my treatment coming up or going or coming?"
>
> — Sudanese client[1]

With the client's permission, brief other healthcare professionals involved in their care about their special needs. If a client needs to attend a number of follow-up specialist appointments or an appointment at a major public hospital, provide as much information as possible. This may include those:

- with complex health needs requiring multiple follow-up appointments
- experiencing practical barriers to accessing care (e.g. transport, childcare)
- whose trauma symptoms interfere with their capacity to arrange and attend appointments
- coming from rural communities in developing countries
- who require clear explanation of the referral process and information about the time and location of appointments; even very basic information such as the fact that public hospital outpatient services are free to the client, can be helpful and relieve anxiety
- who consent for you to contact the specialist or hospital to make the appointment and brief them, by phone or in the accompanying referral letter, about the client's history, circumstances and special needs.

In particular, long waiting periods prior to, or following, treatment or surgery can be a source of stress to a traumatised client and arrangements should be made to avoid these wherever possible. Explain the role of specialists and other health practitioners to the client.

PRACTICE TIP

Where possible, refer to specialists who bulk-bill or to public hospital specialists, noting that a number of specialists have private rooms in public outpatient settings.

Suggest that they take a friend or relative who has been living in Australia for some time with them, both to provide support if they are anxious and to help them to 'negotiate' the system. (A support person should not replace a professional interpreter!). If the client does not have support of this nature, consider a referral to the HSS service provider, a migrant resource centre or a public health service. See Section 11 > Referrals (p.323).

Arrangements for interpreting services should be confirmed prior to referral. The Australian Government, through Translating and Interpreting Service (TIS) National, provides free on-site and telephone interpreting services and document translation to medical practitioners when communicating with patients for all Medicare claimable consultations. GPs, specialists, pharmacists prescribing PBS medications and reception staff working in private practice have free telephone access to interpreters, 24 hours a day, 7 days a week, via the Doctors' Priority Line. On-site interpreters are also available through this service. Interpreters for allied health may be made possible by arrangement with the local community health centre.

Local pathology

If conducting a health assessment that may involve a large number of investigations, or if sending a large refugee family off for investigations all at the same time, it is invaluable to first speak to the local pathology service provider about this, and ensure that they will have the personnel to manage. It is also useful to discuss with the local pathology provider whether they will bulk-bill for the tests ordered. The specialists at the local pathology service are often interested in and keen to assist with advice on the most appropriate investigations for certain diseases and the interpretation of complex and unfamiliar results.

Radiology

It is helpful to explain any intended procedures to the client beforehand, and to ensure if possible that female clients can have a female radiographer/ultrasonographer for sensitive investigations. Any payment or out-of-pocket expenses will also have to be made clear to the client.

Allied health

Try to refer to services that are willing to use interpreters, and provide the allied health professional with appropriate details of the client's refugee background and its impact on their current problems. It is helpful to get detailed feedback from the health professional so that if for example exercises are suggested, the GP can reinforce the same message. Medicare funded allied health is not eligible for fee-free TIS services. Referral to community health or public hospitals is recommended.

Non-interpreted allied health services are not appropriate for those with low levels of English language proficiency.

Public/private hospitals and outpatient specialists

Most refugee clients are unable to afford a stay in a private hospital, or to visit private specialists. Some private specialists run their offices in public hospital settings. Where possible, ensure referral to public outpatient specialists. All Medicare funded medical practitioners have free access to the Translating and Interpreting Service (TIS).

PRACTICE TIP

There are a number of hospitals, specialist clinics, community health centres and private practices with a particular interest in refugee health care. These services may be a useful source of information and advice for doctors and other healthcare workers caring for clients from refugee backgrounds. See Section 11 > Referrals (p.323) for further information, or phone your local community health centre or the service for survivors of torture and trauma in your state or territory.

Complementary therapies and traditional medicine (natural therapies)

The health care provided by doctors and allied health workers can be complemented with natural therapies such as herbal medicine, dietary education and nutritional medicine, relaxation and massage therapies. These therapies are often used in conjunction with Western-style medicine, counselling, psychotherapy, social support and advocacy. Integrated treatment requires close liaison between practitioners.[3] Complementary therapies can be used to help integrate both physical and psychological factors in the origins of pain, and help connect the mind–body element in the healing process.

> "... sometimes I go in to the appointment in a very depressed mood. I go out after the massage hopeful again, optimistic again ... So she does two things at the same time – she treats me emotionally while she is treating me physically."
>
> — Refugee client[4]

Many refugees seek out traditional or culturally familiar medicine through their local community. It is important for GPs to be aware of herbal medicines that refugee clients may be taking. Qualified complementary practitioners can advise about herbal safety and potential herb–drug interactions. Consider affordability if referring to private practitioners. Some Australian agencies for torture and trauma survivors provide access to free complementary therapy services.

Contact details for the agency in each state and territory can be found at the Forum of Australian Services for Survivors of Torture and Trauma website: www.fasstt.org.au.

Complementary therapies can assist refugee health in a number of ways.

Many refugee clients come from countries where traditional medicine is widely practised, and may be reassured by being able to access similar forms of health care in Australia. This can also provide affirmation of the client's culture and healing traditions.[5, 6, 7] Research investigating utilisation of mainstream health services shows that one of the factors identified by refugee clients that influences their utilisation of mainstream health services is whether doctors accept and respect their traditional healing methods alongside orthodox medicine.[8]

They can offer gentle, non-invasive therapy to assist in the management and reduction of chronic pain including joint, back, or muscular pain and headaches.[9] Effective therapy for soft tissue injuries sustained from torture or forced labour include specialist physiotherapy, therapeutic and/or remedial massage and relaxation therapies.

The benefits of herbal remedies, such as St John's wort (Hypericum perforatum),[10] valerian (Valeriana officinalis), hops (Humulus lupulus),[11] kava (Piper methysticum),[12, 13] passionflower (Passiflora incarnata),[14, 15] and massage therapy[16, 17, 18, 19] are well established in the management of many of the physical and psychological sequelae of trauma and torture, including chronic pain, anxiety, depression, insomnia and stress. Other chronic health problems, such as longstanding nutritional and digestive disturbances, will often respond to herbal medicine in combination with nutritional guidance and lifestyle changes. Referral to a qualified herbalist is recommended (with consideration of affordability), as quality, dose and safety issues apply to prescription of herbal medicines. These issues are outlined in references such as Herbs and Natural Supplements: An Evidence-Based Guide,[20] and The Essential Guide to Herbal Safety.[21]

Relaxation techniques in conjunction with massage therapy and herbal medicine may be helpful to clients who are concerned about the side effects or dependency associated with some pharmaceutical medications.

Physical therapies such as massage can help re-establish a person's trust in touch, which is frequently damaged by experiences of trauma and torture.[22]

Psychosomatic complaints are common among refugee clients, and a major reason for referral. Complementary therapies can provide an appropriate adjunct to treatment.

The philosophy of complementary therapies emphasises the client's own understanding of their symptoms as an important step towards recovery. They promote self-care and the client's involvement in treatment goals.

> "When I got prescription from the doctor, I worried a lot, I got worried that I am getting addicted to the medication. And they keep saying to me, when I go to the doctor, you must take your medication, you must take your medication. And I was thinking, I'm getting addicted. It was a fear, a worry in my body."
>
> — Refugee client[23]

References

1. Walker, K. (2005). I Would Rather They Tell Me: Sudanese Refugees' Experiences of Health Assessments: A Pilot Study. Victoria: Department of General Practice, Monash University.
2. Rintoul, A. (2010). Understanding the Mental Health and Wellbeing of Afghan Women in South East Melbourne. Victoria: Monash University.
3. Benson, J. (2004). 'Helping refugees integrate into our community: Reflections from general practice'. Australian Family Physician, 33(1/2).
4. Singer, J. (2008). Listening to Refugee Bodies: The Naturopathic Encounter as a Cross-Cultural Meeting Place. Southern Cross University
5. Hiegel, J.P. (1994). 'Use of indigenous concepts and healers in the care of refugees: Some experiences from the Thai border camps'. In A.J. Marcella (Ed.) Amidst Peril and Pain: the Mental Health and Well-being of the World's Refugees. Washington: American Psychological Association.
6. Mollica, R.F., Cardozo, B.L., Osofsky, H.J., Raphael, B., Ager, A., & Salama, P. (2004) 'Mental health in complex emergencies'. Lancet, 364(9450), 2058–67.
7. Bodeker, G., Neumann, C., Lall, P., & Oo, Z. M. (2005). 'Traditional medicine use and healthworker training in a refugee setting at the Thai-Burma border'. Journal of Refugee Studies, 18(1), 76–99.
8. Henderson, S., & Kendall, E. (2011). 'Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: Exploring the need for improvement in health service delivery'. Australian Journal of Primary Health, 17, 195–201.
9. Prip, K. (2005) Physical Torture Methods and their Sequelae. In K. Prip, L. Tived, & N. Holten (Eds) Physiotherapy for Torture Survivors: A basic Introduction. Copenhagen: International Rehabilitation for Torture Victims.
10. Linde, K., Berner, M.M., & Kriston, L. (2008, October). 'St John's wort for major depression'. Cochrane Database System Review, (4).
11. Koetter, U., Schrader, E., Käufeler, R., & Brattström, A. (2007). 'A randomized, double blind, placebo-controlled, prospective clinical study to demonstrate clinical efficacy of a fixed valerian hops extract combination (Ze 91019) in patients suffering from non-organic sleep disorder'. Phytotherapy Research, 21(9), 847-851.
12. Pittler, M.H., & Ernst, M. (2003). 'Kava extract for treating anxiety'. Cochrane Database Systematic Review, (1): CD003383.
13. Sarris, J., Kavanagh, D.J., Byrne, G., Bone, K.M., Adams, J., & Deed, G. (2009). 'The Kava Anxiety Depression Spectrum Study (KADSS): A randomized, placebo-controlled crossover trial using an aqueous extract of Piper methysticum'. Psychopharmacology, 205(3), 399–407.
14. Ngan, A. & Conduit, R., (2011). 'A double-blind, placebo-controlled investigation of the effects of Passiflora incarnata (passionflower) herbal tea on subjective sleep quality'. Phytotherapy Research, 25(8), 1153–1159.
15. Akhondzadeh, S. Naghavi, H.R., Vazirian, M., Shayeganpour, A., Rashidi, H., & Khani, M. (2001). 'Passionflower in the treatment of generalized anxiety: A pilot double-blind randomized controlled trial with oxazepam'. Journal of Clinical Pharmacy and Therapeutics, 26(5), 363-367.
16. Hou, W.H., Chiang, P.T., Hsu, T.Y., Chiu, S.Y., & Yen, Y.C. (2010). 'Treatment effects of massage therapy in depressed people: A meta-analysis'. Journal of Clinical Psychiatry, 71(7), 894-901.
17. Moyer, C.A., Rounds, J., & Hannum, J.W. (2004). 'A meta-analysis of massage therapy research'. Psychological Bulletin, 130(1), 3–18.
18. Furlan, A.D., Imamura, M., Dryden, T., & Irvin, E. (2008) 'Massage for low-back pain'. Cochrane Database Systematic Reviews, 8(4).
19. Sherman, K.J., Cherkin, D.C., Hawkes, R.J., Miglioretti, D.L., & Deyo, R.A. (2009). 'Randomized trial of therapeutic massage for chronic neck pain'. Clinical Journal of Pain, 25(3), 233–238.
20. Braun, L. & Cohen, M. (2010). Herbs and Natural Supplements: An Evidence-Based Guide (3rd edn). Australia: Churchill Livingstone.
21. Mills, S. & Bone, M. (2005). The Essential Guide to Herbal Safety. USA: Churchill Livingstone.

22. Adams, J. (2006). 'Counsellors' Understanding of Complementary Therapies and the Meaning of Referral'. University of Melbourne. Unpublished research.
23. Singer, J. (2008). Listening to Refugee Bodies: The Naturopathic Encounter as a Cross-Cultural Meeting Place. Southern Cross University.

Section 8:
Strategies for supporting new arrivals to access health services



Orienting new arrivals to the Australian healthcare system

New arrivals may face a number of barriers in accessing and making the best use of health services. Healthcare workers have an important role in addressing these barriers in their work with individuals and groups from refugee backgrounds. Some may also be in a position to implement strategies to streamline the care of new arrivals through service-level initiatives, and in some cases, larger developmental projects involving other professionals and networks. The increasing trend of resettlement in regional and rural areas, where health services may have fewer resources and networks than their metropolitan counterparts, highlights the need for initiatives that promote coordination, collaboration and the sharing of resources among health, settlement, government and community services.

Knowing local migrant resource centres, community centres and family services that support people of refugee background in your local area are important steps to supporting new arrivals to the Australian healthcare system.

KEY POINTS

Supporting individual new arrivals

While the ultimate goal is to assist new arrivals from refugee backgrounds to access healthcare services independently, in the early settlement period at least, more intensive support and advocacy may be required. Developing and implementing service-level procedures can be more effective in orienting new arrivals to the Australian healthcare system and providing consistent care. This can include:

- Clear policies and procedures on use of interpreters.
- Establishing procedures within the health service to ensure all staff are aware of how to book interpreters and have training in how to use them. See Section 2 (p.31).
- Liaising with the client's case manager/worker/volunteer to accompany them to appointments. Agency staff may be in a position to provide this support. Alternatively consider referral to a migrant resource centre for such support. See Section 11 (p.323).
- Keeping data that records interpreter required, preferred language, country of birth and year of arrival.

- Offering assistance in locating a 'bulk-billing' general practitioner (GP) who speaks their language or who has experience in use of interpreters. Divisions of General Practice may have a key role to play at a local level.
- Establishing links between the agency and ethnic support networks who may be able to assist them with accessing bilingual doctors and with practical matters such as transport and child care.
- Encouraging all staff to play a role in orienting new arrivals to the Australian healthcare system and to inform them of their rights and responsibilities as health service users. See Promoting clients' healthcare rights and responsibilities (p.285).
- Establishing links with legal services to support access to information and consultation regarding migration status where this is a concern to the client. See Section 3 > Uncertain migration status (p.54).

Multimedia resources for patients of refugee background

Staying Healthy in Our New Country is a DVD resource produced by AMES Victoria in partnership with Western Region Health Centre, Victoria. The DVD contains information about the health system of Victoria in a series of digital stories for speakers of Burmese, Karen, Chin, Dari, Nepali, Tamil, Dinka, Arabic, Hazaragi, Kiswahili, Assyrian Chaldean, Farsi and English. Topics covered include the role of the GP, making appointments, community health centres, specialists, immunisations, pregnancy, emergency calls, mental health, filling a script and healthy living. To order a copy contact: enquiries@multiculturalhub.com.au.

Health Check: Health Information for Recently Arrived African Communities in Australia (2006). This DVD provides clear information about health checks and procedures in Australia, including information on Medicare, bulk-billing, attending appointments, immunisation, and when to call an ambulance. The resource is available in English, Dinka, Kirundi, Swahili, Juba Arabic or Liberian Pidgin English. Copies can be obtained at a small cost through the NSW Refugee Health Service: telephone (02) 9391 9000.

Your Pregnancy, Your Health (2008) is a DVD produced by the Diversity Health Institute Clearing House for Somali, Dinka and Arabic speaking women and their families. It provides information about pregnancy for people who have recently arrived in Australia. Topics covered include staying healthy in pregnancy, the importance of seeking antenatal care, when and where to find pregnancy information and care available to all pregnant women in NSW. Distribution is through the Auburn Hospital's Multicultural Health Unit: telephone (02) 8759 3828. This is a free resource.

Building Strong Families: A Guide for New Migrants to Australia (2010) is a DVD about how family roles and dynamic may change or differ from those experienced in home countries. The resource is available in Arabic, Burmese, Dari, Dinka, Farsi, Haka-Chin, Karen, Nepali and Tamil. To order copies ($30 + postage and handling) contact Relationships Australia Victoria: telephone (03) 8573 2222 or via an email to reception@rav.org.au.

PRACTICE TIP

Introducing general practice

Take opportunities to encourage people to see a local GP for general medical care rather than going to a hospital. Many people will have accessed health care through larger clinics in their home countries, where their relationship would have been with the clinic rather than with the individual doctor as is the case in Australia. New arrivals may seek general medical care through hospital emergency or 'casualty' departments, because this is a style of provision they are familiar with. Some may believe hospitals offer a better standard of care. However, being established to respond to health emergencies, hospitals are not appropriate settings for general medical care, and a long wait may be involved.

Strategies for working with groups of new arrivals in a community or service setting:

- Provide tours of local health services. Experience suggests this is highly effective as it is personalised and interactive. Clients can register and arrange an appointment with the service at the time of the tour.

- Offer group information sessions on the health system. Visual resources about health services in the client's own language will facilitate understanding.
- Offer group exercises simulating aspects of accessing and using health services that might be difficult for new arrivals (e.g. organising an appointment, asking for an interpreter, discussing medication).
- Invite local healthcare providers to speak to the group about their service or their professional role.
- Review how your service can be complemented by additional support and coordination with other services in order to maximise support for refugee clients.

KEY POINTS

Promoting clients' healthcare rights and responsibilities

Services can encourage appropriate staff (practitioners, reception, auxiliary) to inform refugee clients of the following:

- The client's right to choose their treating doctor and to exercise control over their treatment. This includes the right to seek a second opinion and to say 'no' to procedures they feel uncomfortable with.
- The role of illness prevention and the importance of seeking health care as soon as possible when a problem is detected.
- The fact that people can talk to their doctors about emotional issues that may be troubling them.
- The importance of providing as much information as possible (including any medical records) to assist healthcare providers in making an accurate diagnosis and offering appropriate treatment. Encourage people to tell their doctor that they are a new arrival, what countries they have stayed in on their journey to Australia, what their living conditions were like and how long they were there.
- The fact that health practitioners are bound by law and professional ethics to maintain confidentiality unless their client consents to information being passed on to others.
- The role of, and ethical guidelines for, accredited interpreters in a healthcare setting.

- The notion of health as a 'partnership' between healthcare provider and client. This is important as many new arrivals will be used to very different doctor-client relationships and may be unaccustomed to health professionals discussing options for treatment, encouraging questions and explaining procedures.
- That Australian doctors may prescribe medication less than in the client's country of origin. In some cases this is because health research has shown that some illnesses are best left to get better by themselves (e.g. viruses). Sometimes health problems such as headaches or difficulties in sleeping are caused by stress. The doctor might feel that it is better to talk about these problems in order to resolve them. However, it is important to encourage people to seek a second opinion if they feel the doctor has provided inadequate treatment or not taken their problem seriously.

Enhancing access

Practitioners may be in a position to implement some of the following strategies in their service or practice to enhance accessibility to refugee clients and to streamline their care:

- Collecting information on the demographic profile of the catchment area of your service in order to plan for possible refugee background clients.
- Providing Interpreter cards to clients. Interpreter cards are wallet-sized cards that state the languages that the client speaks. You can order cards and information packs about the cards from the Australian Government Translating and Interpreting Service: tispromo@immi.gov.au.
- Introducing a system for booking interpreters. This may involve enlisting the support of reception staff. For information on booking procedures through the Translating and Interpreting Service, for GP services and for state funded services, see Section 2.
- Introducing a client-held record providing consultation summaries and medication and immunisation records. This assists clients in accessing other healthcare services, optimises continuity of care in the event that the client moves (not uncommon in the early settlement period) and reduces the risk of unnecessary repeat procedures and investigations.
- Marking the files of refugee clients to aid in future identification and assist in meeting special needs (e.g. interpreter requirements).

- Maintaining a list of local service providers to whom new arrivals can be referred, including health professionals who have experience in working with people from refugee backgrounds and/or who speak relevant languages, specialists, GPs and allied health practitioners who bulk-bill, as well as settlement agencies.
- Keeping up to date with changes in policies, entitlements and services affecting people from refugee backgrounds (e.g. changes to the Medicare fee structure, interpreter services).
- Developing links with refugee communities who can provide advice on cultural factors affecting care.
- Translating the organisation's most frequently used forms and letters into languages spoken by clients.
- Ensuring that staffs are aware of available multilingual health information and that they know how to access and use it.
- Obtaining pictorial charts and posters to facilitate communication with the client.
- Familiarising yourself with relevant country background information. See Section 10 (p.309).
- Making arrangements for peer consultation and case discussion.
- Recruiting bilingual staff from refugee background communities who can facilitate communication and share their cultural knowledge.

Refugee oriented services: case examples

A number of Australian health and support services serving refugee communities have undertaken developmental projects aimed at ensuring their own responsiveness to refugee clients, enhancing their clients' access to other services and supports, and improving collaboration and communication between agencies. These have included:

- allied health and support workers making practice visits to local GPs and other healthcare services and encouraging them to establish an interpreter booking system and other supports to make their practices 'refugee-friendly'
- making contact with the local Division of General Practice to discuss the concerns of people from refugee backgrounds and explore ways of working together to respond to these
- developing service-level protocols to ensure that refugee clients are identified and that they are offered appropriate care
- enhancing care coordination, peer support information exchange and advocacy by establishing a network of local groups and services with an interest in refugee health

- producing information on local healthcare services and transport options in relevant languages to assist people in accessing services
- identifying and making contact with groups who might benefit from information sessions on health services (for example adult English as a second language classes, mosque groups, women's support groups, secondary-level English language centres and schools)
- awareness-raising about refugee health issues among local service providers (e.g. including information in organisational newsletters)
- establishing positions for refugee health specialists in metropolitan public hospitals to answer queries about treating refugee patients in general practice and specialist contexts.

Victorian Refugee Health Nurse Program

The Refugee Health Nurse Program (RHNP) began in 2005 in response to the poor and complex health issues of arriving refugees.

The program aims to:

- Increase refugee access to primary health services.
- Improve the response of health services to refugees' needs.
- Enable individuals, families and refugee communities to improve their health and wellbeing.

The program provides services to refugee and asylum seeker clients and in 2012 the program operates in areas where data demonstrates high numbers of newly arrived refugees are settling. The program is currently based in 8 metro and 8 regional/rural community health services and employs 26 nurses which equates to 13.5 EFT. The Refugee Health Nurses (RHNs) have expertise in working with culturally and linguistically diverse and marginalised communities and they provide a coordinated health response to refugees and asylum seekers. The Refugee Health Fellows Program based in the Victorian Infectious Diseases Service at the Royal Melbourne Hospital provides advice and secondary consultation.

RHNs provide initial health screening, direct nursing care (such as catch-up immunisations), case management and health education. They also facilitate client access to GPs, specialists, dental care, mental health services, schools and community support services.

To refer to a Refugee Health Nurse in your local area visit the referrals page of the Victorian Refugee Health Network website www.refugeehealthnetwork.org.au.

Further information on the program is available from the Victorian Department of Health website www.health.vic.gov.au/pch.

Funding a refugee health program coordinator within a practice division, Victoria

The City of Greater Dandenong and surrounding region is one of the principal destinations for Refugee and Humanitarian Entrant resettlement in Victoria, with up to 1,000 new arrivals per year. This population group presents with a wide range of unique health, wellbeing and social issues. Recognising the need for targeted support to primary healthcare providers in the area, the Dandenong Casey General Practice Association applied for funding for a refugee health program coordinator. This role has allowed the association to deepen its focus on refugee health, including:

- direct support to general practices, assisting general practitioners to provide comprehensive refugee health assessments for new arrival refugees
- working in partnership with the AMES Settlement in refugee resettlement health issues
- working with the Southern Health Network to build refugee-specific services
- coordinating regional refugee health activities with stakeholders.

Coffs Harbour Refugee Clinic, New South Wales — a regional experience

In the last decade increasing numbers of new arrivals have started to resettle in rural and regional Australia. This presents unique problems for rural and regional health services. Among the first group of arrivals to Coffs Harbour, a regional town on the mid-north coast of New South Wales was a family with a TB Health Undertaking. The public health/TB nurse consultant in Coffs Harbour managed their care. She became informed of the clients' background, pre-arrival screening and a range of cultural and settlement issues affecting the provision of health care. Seeing the need for collaboration among local health providers, she worked with local services and GPs in the community to better understand the needs of the refugee clients and provide appropriate care. A key task was to organise the transfer of health information (Health Manifest and Health Undertaking) from the NSW Refugee Health Service to local health practitioners.

As with many regional towns, Coffs Harbour does not have the personnel and resources found in metropolitan areas and it was initially difficult to locate public antenatal services and doctors who provided bulk-billing. Refugee clients often experienced difficulties in making appointments, understanding the cost of services, organising transport, and getting prescriptions dispensed. Many health problems of new arrivals are complex, including TB, anaemia, hypertension and lack of immunisation.

In response to this the North Coast Area Health Service (NCAHS) in partnership with the Mid North Coast Division of General Practice (MNCDGP) established a dedicated refugee health clinic in 2006 with the support of local doctors, who are rostered at the clinic once a fortnight. Each doctor provides 4 hours of service twice every 10 weeks. Availability of doctors is an ongoing issue. The clinic performs initial health assessments, culturally appropriate care and referral and support to access health services, including general practice. It has become the largest rural refugee health clinic in Australia. A tool to screen and assess clients has been developed and refined. The clinic received funding in February 2006 to employ a refugee health nurse and coordinator of the clinic. Collaboration with the local school nurse, who conducted an immunisation survey of refugee families, enables a targeted approach to ensure all families have immunisation catch-up.

Refugee Health Queensland

Refugee Health Queensland commenced operation in 2008, after a decade of lobbying by committed health and community workers. Following the introduction of Temporary Protection Visas (TPVs) in 1999 and the associated lack of access to Medicare, a group of health and community workers and organisations formed the Brisbane Refugee and Asylum Seeker Heath Network (BRASHN). BRASHN was a voluntary group that coordinated volunteer health workers to provide health care to Asylum Seekers and people on TPVs. Lobbying continued for dedicated funding for a refugee health service and the Queensland Integrated Refugee Community Health (QIRCH) Clinic was opened in 2002. QIRCH provided Nursing and GP services to approximately 200 refugees per annum with complex health needs and asylum seekers without access to Medicare. In 2005 a number of large groups of refugees arrived with the need for urgent health care and treatment, which further highlighted the fact that the mainstream health system was not equipped to support the health needs of refugees and further highlighted the need for an on-arrival health assessment refugee health service. With further lobbying and discussions with Queensland Health, funding was acquired by the Queensland Health Multicultural Health Services to develop a statewide refugee health service for all newly-arrived refugees and Refugee Health Queensland (RHQ) was born.

RHQ is an early-health assessment service with a hub and spoke model. The hub (central office) is based in South Brisbane and has a part-time Clinical Director and a Statewide Coordinator. The spokes are Refugee Health Clinics and are based in the key refugee settlement areas in Queensland: Brisbane north (Zillmere) and south (Woolloongabba), Cairns, Logan, Toowoomba and Townsville. All RHQ-funded clinics provide a nursing assessment and immunisations, with referrals to a community GP for ongoing care. The Brisbane clinics both have GPs, with the Zillmere Clinic providing assessment and specialist referrals and the South Brisbane Clinic medical assessments, pathology collection and commencement of treatment. QIRCH still exists as the Extended Care stream of the South Brisbane Clinic and provides high-quality, complex health care management for refugees and asylum seekers.

For more details visit the Refugee Health Queensland website: www.refugeehealthqld.org.au.

Darwin Refugee Health Service

The Darwin Refugee Health Service started its operations out of a private GP practice in June 2009. Prior to this, health services had been provided to new arrivals in the Territory by the NT Centre for Disease Control which did not receive any earmarked funding to perform initial assessment or ensure follow up and referral for refugee clients. Recognising the gap in health service provision to refugee communities, funding was successfully lobbied with the Northern Territory Department of Health contracting the General Practice Network of the Northern Territory (GPNNT) to provide a specialist refugee health program. The GPNNT used this funding to help establish a refugee health service within a pre-existing GP surgery.

The Darwin Refugee Health Service provides initial health assessment, catch-up immunisation, care management and referral to specialist services and is currently staffed by 1 full time Refugee Nurse and 2 GPs with knowledge of refugee health care. The funding allows the GP surgery to bulk-bill people of refugee background for the first 12 months after their visa grant, and has made the development of resources to support new arrivals possible. One such resource is a refugee health orientation manual, which includes plain English explanations of the Northern Territory health system, including pictures local hospitals and other health services, maps and transport routes, information on accessing an interpreter and on patient rights. Health promotion initiatives are also undertaken at the service, and after the initial 12 months of support, most clients of refugee background feel equipped to engage with local primary and preventative health care services. Many choose to stay on at the GP surgery from which Refugee Health Service is run.

Referral to the clinic is made via the Territory's HSS provider, Melaleuca Refugee Centre. Since the Health Service commenced in 2009 100% of new arrivals (200 a year) to the Territory have been seen, treated and supported by clinic staff.

Section 9:
Health entitlements and settlement support





Owing to the hurried, unplanned and traumatic nature of their departure, most people from refugee backgrounds arrive in Australia with few resources. Many are unable to speak English. Basic systems such as public transport, hospitals and banking are unfamiliar to them.

At the same time, they are faced with the enormous tasks of settlement – arranging housing, establishing a household, obtaining employment, settling their children into school, and arranging English language classes, income support payments and healthcare entitlements. They often have limited family and community support.

Supporting new arrivals to accomplish the tasks of settling in a new country can have a significant impact on both their physical and mental health.

This section is divided into two groups depending on a person's visa status:

- humanitarian entrants
- asylum seekers.

There are also people of refugee background who may be in Australia on student, skilled migrant or other visas who may not be Medicare eligible. In addition, there are individuals who may not have formalised their status, typically when their visa has expired, and so have no valid visa at all.

Support and benefits under the Humanitarian Program

Entrants granted permanent residence in Australia through the Humanitarian Program (either onshore or offshore) are entitled to the same services and benefits available to other Australians.

In the early settlement period (usually the first 6 months), entrants are provided with support through the Australian Government Humanitarian Settlement Services (HSS) program. Services include help with establishing rental accommodation, linkage with mainstream services and general orientation (e.g. use of public transport, access to health care, education and Centrelink). Each family is assigned an HSS settlement case manager who assists with this orientation process.

After the initial 6 month period (the HSS supported period), people of refugee background are provided with ongoing support via the federal government funded Settlement Grants Program (SGP). SGP providers, such as migrant resource centres (MRCs), adult migrant English programs (AMEP) and local government organisations provide ongoing support to migrants and people of refugee background. These organisations usually do not provide case management.

Complex Case Support (CCS) is a case management service offered to recently arrived refugees whose complex or intensive settlement-related needs cannot be met within the scope of other mainstream settlement services. Clients may be eligible for CSS up to 5 years after arrival. CSS services are usually intensive and short-term (a few days up to 6 months).

FIGURE 9.1 **Settlement support services**

Humanitarian Settlement Services (HSS)

provide initial settlement help and support to newly arrived refugees (usually up to 6 months after arrival but occasionally up to 12 months). Services include assistance with establishing rental accommodation, linkage with mainstream services and orientation (for example use of public transport, access to healthcare, education and Centrelink). See Section 11 (p.323) for providers in your state or territory.

Settlement Grants Program (SGP)

provides ongoing support to people of refugee background after their initial settlement period (i.e. after the Humanitarian Settlement Services supported period, outlined above). SGP services might include Migrant Resource Centres (MRCs), Adult Migrant English Programs (AMEP) and local government organisations. While these organisations do not usually provide case management, they do provide information and referral services for people of refugee background. See Section 11 (p.323) for providers in your state or territory.

Pre-settlement experience

6 to 12 months after arrival or onshore visa grant

Up to 5 years after arrival or onshore visa grant

Complex Case Support (CCS)

is a case management service offered to recently arrived refugees whose complex or intensive settlement-related needs cannot be met within the scope of the other mainstream settlement services. Clients may be eligible for Complex Case Support up to five years after arrival in Australia. CCS services are usually intensive and short term (from a few days up to a maximum of 6 months). For more information phone 1300 855 669

TABLE 9.1 Entitlements of humanitarian entrants by program category

	Humanitarian entrants			Asylum seekers	
	Offshore Program		Onshore Program		
	Refugee	Special Humanitarian Program (SHP)	Onshore Visa Grant (after having sought asylum)	Community Detention	In community
Visa Subclass	200 Refugee 201 In Country Special Humanitarian 203 Emergency Rescue 204 Woman at Risk	202 Global Special Humanitarian	866 Permanent Protection Visa	No visa (client is legally detained)	Bridging Visa A (BVA) Bridging Visa C (BVC) Bridging Visa E (BVE) Visa conditions vary and may include work and study rights
Airfares to Australia	Yes	No	No	No	No
Income support through Centrelink	Immediate access to full range of social security benefits	Immediate access to full range of social security benefits	Immediate access to full range of social security benefits	Asylum seekers in Community Detention do not have access to any Centrelink payments of any kind. Asylum seekers in Community Detention receive some income support via the Red Cross, usually at a rate of 70% of the Centrelink Special Benefit equivalent.	Asylum Seekers are not eligible for Centrelink payments of any kind. Some asylum seekers are eligible for income support via the Red Cross, facilitated through the Asylum Seeker Assistance Scheme (ASAS) and the Community Assistance Support (CAS) program, calculated at a rate of 89% of the Centrelink Special Benefit equivalent.

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TABLE 9.1 Entitlements of humanitarian entrants by program category continued

	Humanitarian entrants			Asylum seekers	
	Offshore Program		Onshore Program		
	Refugee	Special Humanitarian Program (SHP)	Onshore Visa Grant (after having sought asylum)	Community Detention	In community
Work Rights & Job Search Assistance	Same eligibility as other Australians	Same eligibility as other Australians	Same eligibility as other Australians	Asylum seekers in community detention are not eligible for work rights.	As of July 1 2009, most asylum seekers who are granted a Bridging Visa while waiting for the outcome of their asylum application are granted permission to work (unlimited). If the visa was granted prior to 2009 and the bridging visa does not give permission to work, individuals can apply for work rights, which may or may not be approved. If an individual's visa (student visa, tourist visa, etc) expired and they did not seek a new one within the allocated timeframe then their Bridging Visa may not come with work rights.1
Medicare	Yes	Yes	Yes	Asylum seekers in Community Detention are not eligible for Medicare. Their health care is provided through the International Health and Medical Services (IHMS) provider network. IHMS can generally fund public health equivalent healthcare charged at the Medicare rate.	Regardless of which Bridging Visa someone holds, as long as there are work rights attached the visa holder can access Medicare. Asylum seekers who are ineligible for Medicare may be eligible for ASAS or CAS. In some states/territories Medicare ineligible asylum seekers have access to state/territory health services.

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TABLE 9.1 Entitlements of humanitarian entrants by program category continued

	Humanitarian entrants			Asylum seekers	
	Offshore Program		Onshore Program		
	Refugee	Special Humanitarian Program (SHP)	Onshore Visa Grant (after having sought asylum)	Community Detention	In community
Health Care Card	Yes	Yes	Yes	Asylum seekers are not eligible for a Health Care Card, meaning they cannot access subsidised medications or other Health Care Card entitlements.	Asylum seekers are not eligible for a Health Care Card, meaning they cannot access subsidised medications or other Health Care Card entitlements. Clients eligible for Red Cross administered programs are eligible for subsidised medication to the Health Care Card equivalent subsidy.
Pharma-ceutical Benefits Scheme	Yes	Yes	Yes	Not eligible. Pharmacies within the IHMS network invoice IHMS for approved pharmaceutical expenses.	Not eligible
Short-term torture and trauma counselling	Yes	Yes	Yes	Yes	Yes
English Classes	Access to English language services through AMEP. 510 hours of English classes or classes until a functional level of English is established.	Access to English language services through AMEP. 510 hours of English classes or classes until a functional level of English is established.	Access to English language services through AMEP. If over 25, access to up to 510 hours, if under 25 and low level of schooling, up to 910 hours	DIAC have a contract with AMEP to provide a limited number of part time, short term English classes for Community Detention clients. Access to English as a Second Language schools and mainstream schools for school-aged children.	There is no formal DIAC funding for asylum seekers on bridging visas to access English classes. Some community and tertiary organisations have special arrangements for this group.

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TABLE 9.1 Entitlements of humanitarian entrants by program category continued

	Humanitarian entrants			Asylum seekers	
	Offshore Program		Onshore Program		
	Refugee	Special Humanitarian Program (SHP)	Onshore Visa Grant (after having sought asylum)	Community Detention	In community
Interpreting and translating services	Yes – access to free translating and interpreting service for document translation, for making appointments and with key public health and education services	Yes – access to free translating and interpreting service for document translation, for making appointments and with key public health and education services, via TIS	Yes – access to free translating and interpreting service for document translation, for making appointments and with key public health and education services, via TIS	Eligible to access telephone interpreters via Translating and Interpreting Service (TIS), not eligible for translation of documents	Eligible to access telephone interpreters via Translating and Interpreting Service (TIS), not eligible for translation of documents
On-arrival accomm-odation services	Eligible for short term on-arrival accommodation. Assistance and provision of basic household goods to establish home. In some states, long-term accommodation is sourced pre-arrival. Settlement support services also assist in finding and renting accommodation.	Proposer responsible for finding accommodation however if assessed as unable to assist, then assistance to find appropriate accommodation is provided (including short term on-arrival accom modation). Provision of basic household goods to establish home.	Eligible for short term accommodation and assistance to find appropriate accommodation and provision of basic household goods to establish home, on a needs basis	It is a condition of Community Detention that clients reside at an agreed address, including with identified community members and in Red Cross rented properties.	Not eligible for government funded accommodation services. In some states asylum seekers are eligible for transitional housing.

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TABLE 9.1 Entitlements of humanitarian entrants by program category continued

	Humanitarian entrants			Asylum seekers	
	Offshore Program		Onshore Program		
	Refugee	Special Humanitarian Program (SHP)	Onshore Visa Grant (after having sought asylum)	Community Detention	In community
Settlement support	Access to range of services, including HSS case management based on initial needs assessment, information, referral to service providers. Settlement support generally for 6 months following arrival may be extended to 12 months. Referrals to health services on arrival under HSS case manager.	Support provided to proposer. Access to a range of services, including HSS case management based on initial needs assessment; information and referral to service providers. Settlement support generally for 6 months following arrival, up to 12 months. Referrals to health services on arrival under HSS case manager.	Access to range of services, including HSS case mangement based on initial needs assessment, information, referral to service providers. Settlement support generally for 6 months following arrival may be extended to 12 months. Referrals to health services on arrival under HSS case manager.	After grant of a protection (866 visa), asylum seekers have access to HSS services, as per the column to the left of this one.	After grant of a protection (866 visa), asylum seekers have access to HSS services.
Education	Same eligibility as other Australians	Same eligibility as other Australians	Same eligibility as other Australians	Access varies between states/territories. Full fees charged for tertiary and further education (some states/territories give limited access).	Asylum seekers do not have access to HECS of FEE-HELPF and are required to pay full fees for tertiary education (except when accessing special asylum seeker arrangements).

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TABLE 9.1 Entitlements of humanitarian entrants by program category continued

	Humanitarian entrants			**Asylum seekers**	
	Offshore Program		Onshore Program		
	Refugee	Special Humanitarian Program (SHP)	Onshore Visa Grant (after having sought asylum)	Community Detention	In community
Family Reunion	Ability to propose immediate family members (spouse and children) and propose other family members to Australia	Ability to propose immediate family members (spouse and children) and propose other family members to Australia	Ability to propose immediate family members (spouse and children) and propose other family	No access to family reunion rights.	No access to family reunion rights
Travel Overseas	Same eligibility as other Australians	Same eligibility as other Australians	Same eligibility as other Australians	No rights to travel and return without voiding asylum application	Only holders of a Bridging Visa C can leave the country and return without voiding their visa, and only under some conditions[1]

Humanitarian Settlement Services (HSS)

Humanitarian Settlement Services (HSS) provides intensive settlement support to newly arrived humanitarian entrants. Through a case management approach, the needs of humanitarian entrants are identified and addressed by providing them with settlement services that meet their particular circumstances.

HSS focusses on equipping entrants to gain access to mainstream services and achieve self-sufficiency as soon as possible. HSS services are generally provided for around 6 months, but may be extended for particularly vulnerable clients for up to 12 months. See www.immi.gov.au/media/fact-sheets/66hss.htm.

Services provided under the HSS are:

- case coordination
- information and referral
- a case plan based on an initial needs assessment
- on-arrival reception and assistance, which includes meeting eligible entrants on arrival, taking them to suitable accommodation, providing initial orientation and meeting any emergency needs for medical attention or clothing and footwear
- accommodation services, which help entrants to find appropriate and affordable accommodation, typically in the private rental market, and provides them with basic household goods to start establishing their own household in Australia.

Contact details for HSS services are available from the DIAC website: www.immi.gov.au/living-in-australia/settle-in-australia/find-help/hss/hss_service_providers.pdf.

KEY POINTS

SETTLEMENT SUPPORT SERVICES

- The Humanitarian Settlement Service provides support in the first 6 months after arrival, contact patient's case manager for more information
- Migrant Resource Centres provide support to new arrivals after their first 6 months in Australia.

Your client may need a referral to a migrant resource centre if they:

- have housing problems
- are not attending English language classes
- do not know where or how to enrol their children in school
- need information on legal or migration issues (e.g. sponsorship)
- do not appear to be receiving appropriate income support payments through Centrelink
- do not appear to have adequate clothing or household goods
- are having trouble finding employment
- are having trouble finding child care
- require complex medical follow-up
- do not appear to have support from family or friends
- need an advocate.

Proposers

'Proposers' are individuals or organisations in Australia who formally agree to provide entrants with support in their settlement. A Proposer must be an Australian citizen or permanent resident or eligible New Zealand citizen. For a person to be considered for entry to Australia under the Special Humanitarian Program (SHP), a proposer is required. While proposers play a very important role, many are from communities which are just beginning to establish in Australia. While this makes them familiar with the needs of refugees, they may also have limited resources to provide support.[2] This is particularly the case in regional areas and the less populated states and territories of Australia where refugee communities are smaller and there are fewer support and specialist services.[3, 4] Alternatively, Proposers from refugee communities may have resided in Australia for some years and have little knowledge of the experiences of recent arrivals and therefore be ill prepared for the demands of their role. Support is available to proposers and entrants through the HSS. This support includes information and guidance on how to assist the entrant to settle in Australia, gain access to available services and obtain further assistance if required after the entrant's arrival.

Further information is found at: www.immi.gov.au/living-in-australia/settle-in-australia/find-help/refugee_humanitarian/help-for-proposers.htm.

Asylum seekers

Asylum seekers entering with valid documentation, such as a student or working holiday visa, are permitted to remain in Australia while their application for refugee status is considered. However, they are not entitled to the settlement support offered to entrants whose immigration status is determined prior to arrival in Australia, nor to many of the benefits and services provided to Australian residents (e.g. income support, English language classes).

Many asylum seekers, like other refugees will have had a history of exposure to trauma and torture and may not have had access to good quality health care for some time. As a result, their health status may be seriously compromised. Studies show that the lack of appropriate access to medical care causes serious stress to asylum seekers living in the community.[5, 6, 7]

The Australian Government provides assistance to some asylum seekers during the period in which their applications for protection are being processed. This can include access to work rights and a Medicare card. Some asylum seekers are eligible for the Asylum Seeker Support Scheme (ASAS) and the Community Assistance Scheme (CAS) provided by the Red Cross.

RESOURCES

Asylum seeker fact sheet

A fact sheet explaining the entitlements of asylum seekers can be accessed on the Victorian Refugee Health Network website: www.refugeehealthnetwork.org.au/_literature_90300/VRHN_AS_Factsheet_(added_11_Aug_2011).

Access to hospital care

Australian public hospitals have a duty of care at common law which curtails the refusal to provide emergency care regardless of a client's capacity to pay. For non-emergency circumstances, however, Australian states and territories have different policies concerning asylum seekers' access to hospital services. In Victoria and the ACT, for example, Medicare-ineligible asylum seekers are provided full medical care, including pathology, diagnostic, pharmaceutical and other services in public hospitals. Clients in this category are not to be billed.

In other states and territories, hospitals may seek to recover costs later if they believe a client has income or assets, or is eligible for ASAS.

In a number of Australian states, community based organisations in collaboration with healthcare professionals have established primary healthcare clinics free of charge to Medicare-ineligible asylum seekers. For information on these clinics, see Section 11 (p.323).

- Victoria hospital circular: www.health.vic.gov.au/hospitalcirculars/circ05/circ2705.htm
- ACT policy: www.health.act.gov.au/c/health?a=dlpol&policy=1172541634&did=10107160&sid.

Asylum Seeker Assistance Scheme (ASAS)

The Asylum Seeker Assistance Scheme (ASAS) provides financial assistance, material aid and health care to eligible asylum seekers. Currently operating in all states and territories ASAS is facilitated by the Red Cross.

For ASAS offices see Section 11 (p.323).

Community Assistance Support (CAS)

Clients referred to Red Cross run Community Assistance Support (CAS) program are highly vulnerable and usually have complex needs. The program provides help to these clients by addressing their basic health and welfare while their immigration status is being resolved.

CAS provides the following services:

- complex casework support
- income support to cover basic living expenses (89% of Centrelink Special Benefit)
- access to health care
- access to counselling
- assistance with accessing accommodation; crisis, medium term and supported accommodation through referrals to housing service providers
- other assistance as agreed to meet client needs
- transition support for some vulnerable people leaving immigration detention facilities who have been granted a substantive visa.

RESOURCES

Further information can be found at:

Australian Red Cross Asylum Seeker Assistance Scheme (ASAS): www.redcross.org.au/ourservices_acrossaustralia_asas_default.htm

Department of Immigration And Citizenship; Assistance for Asylum seekers In Australia, Fact Sheet 62: www.immi.gov.au/media/fact-sheets/62assistance.htm

Royal Australian College of General Practitioners (RACGP) Refugee and Asylum Seeker Health Resource Centre www.racgp.org.au/refugeehealth

NSW Refugee Health Service Fact Sheet: Asylum Seekers and Health in Australia: www.swsahs.nsw.gov.au/areaser/refugeehs/files/Fact%20Sheet%203%20Asylum%20seekers%202004.pdf.

Community and non-government agencies perform a significant role in providing health, financial and social support to asylum seekers. See Section 11 > Referrals

Medical documentation of torture injuries for reports

Asylum seekers may request a medical report about their injuries which have been sustained as a result of torture or the psychological effects of torture and trauma. A health practitioner may be in a position to provide this information. It is important to follow the guidelines on the preparation of medical reports as there are a number of issues that are important to consider.[8, 9, 10] These include:

- familiarity with the refugee determination processes
- knowledge of other agencies and services providing supporting documentation (e.g. legal services)
- experience in medico-legal reports.

Guidelines to writing medical reports for asylum seekers can be found at:

The Torture Reporting Handbook: www.essex.ac.uk/torturehandbook/handbook/part_iii_2.htm.

International Rehabilitation Council for Torture Victims (IRCT) website: www.irct.org/Default.aspx?ID=606.

References

1. Lawon, D. & Dutertre, S. (2011). The Impact of Visa Restrictions and Entitlements for Young People who Come and Live in Australia. Melbourne: Centre for Multicultural Youth (CMY).
2. Francis, S. & Price, G. (1996). Refugees and Shelter in Australia: Report of the On-Arrival Accommodation Project. Ecumenical Migration Centre.
3. Mitchell, J. & Irvine, J. (2001). 'Community Development and Recovery: Reflections on Working with African People in an Isolated Region of Australia'. (Unpublished).
4. Taylor, J. & Stanovic, D. (2005). Refugees and Regional Settlement: Balancing Priorities. Fitzroy: Brotherhood of St Laurence. Retrieved from: < www.bsl.org.au/pdfs/refugees_and_regional_settlement.pdf >.
5. Silove, D., Steel, Z., Susljik, I., Frommer, N., Loneragan, C., Brooks, R., le Touze, D., Manicavasagar, V., Coello, M., Smith, M., & Harris, E. (2006). 'Torture, mental health status and the outcomes of refugee applications among recently arrived asylum seekers in Australia'. International Journal of Migration, Health and Social Care, 2(1), 4–14.
6. Sinnerbrink, I., Silove, D.M., Manicavasagar, V.L., Steel, Z., & Field, A. (1996). 'Asylum seekers: General health status and problems with access to health care'. Medical Journal of Australia, 65, 634–637.
7. Correa-Velez, I., Gifford, S., & Bice, A. (2005). Australian health policy on access to medical care for refugees and asylum seekers. Australian and New Zealand Health Policy, 2, 23. Retrieved from: < www.anzhealthpolicy.com/content/2/1/23 >.
8. Amnesty International (1991). Examining Torture Survivors Articles and Guidelines: A Reference Book. Copenhagen: International Rehabilitation Council for Torture Victims (IRCT).
9. Gifford, C. (2000). The Torture Handbook: How to Document and Respond to Allegations. Essex: Human Rights Centre, University of Essex.
10. International Rehabilitation Council for Torture Victims (IRCT) (2004). Medical Physical Examination of Alleged Torture Victims: A Practical Guide to the Istanbul Protocol for Medical Doctors. Copenhagen: IRCT.

Further reading

Marston, G. (2003). Temporary Protection Permanent Uncertainty: The Experience of Refugees Living on Temporary Protection Visas. Melbourne: Centre for Applied Social Research, RMIT University. Retrieved from: < mams.rmit.edu.au/k2vavbh0g5ik.pdf >.

Section 10:
Country profiles and refugee health information websites



Primary care for refugee clients begins with understanding the prior circumstances and conditions to which they have been exposed. An understanding of the client's country background, flight history and exposure to infectious disease and psychological trauma will help primary health care practitioners to focus medical care and screening. As a result of changing global circumstances, the country of origin of people entering under the Refugee and Humanitarian Program changes significantly over time.

There are many helpful websites that provide detailed information on the countries of origin and transit of refugee communities in Australia. A number of websites provide community profiles and information for health professionals who may be unfamiliar with the country background, languages, health conditions or health practices of refugee communities in Australia.

Direct addresses are provided with a brief guide as to what is found at each of the sites.

Please note that these websites may change and require a search of the host organisation's homepage. The producers of this resource do not endorse or take responsibility for the content provided in these websites.

Country of origin and transit information

United Nations sources

United Nations Children's Fund (UNICEF)

www.unicef.org/infobycountry/index.html
The UNICEF website provides country information, statistic reports and audiovisual material relating to the wellbeing of children.

UNICEF State of the World's Children Reports

www.unicef.org/sowc2011/index.php
The State of the World's Children is an annual report on the health and wellbeing of children and adolescents worldwide. The 2011 report is called 'Adolescence: An Age of Opportunity'.

UN Joint United Nations program on HIV/AIDS (UNAIDS)

www.unaids.org/en/
UNAIDS provides data, information and reports on HIV/AIDS in countries and regions of the world.

United Nations High Commissioner for Refugees (UNHCR)

www.unhcr.org
The Home Page of UNHCR includes a drop down menu of country of origin information, including statistics, country situation overviews, select reports and documents relating to refugee law and the health of refugees around the world.

UNHCR Refworld

www.refworld.org
Refworld is UNHCR's document repository. Items include facts, statistics, research, regional and country reports, educational resources and legal documents.

World Health Organization (WHO)

www.who.int/en/
This site provides access to the World Health Organization website. The WHO is the United Nations specialist agency for health.

WHO Country Information

www.who.int/countries/en/
This website allows you to view country profiles, statistics and information on health indicators, disease outbreaks, immunisation coverage, health resources, specific conditions including HIV/AIDS, polio, tuberculosis and oral health problem prevalence rates.

WHO Child and Adolescent Health and Development

www.who.int/child-adolescent-health/publications/pubCNH.htm
This site provides extensive, searchable information, data and statistics and resources on health, growth and development outcomes for the group from birth to 19 years of age in many countries of the world.

WHO Disease Outbreak News

www.who.int/csr/don/en/ and www.who.int/csr/don/archive/country/en/index.html
These two sites provide current information on disease outbreaks and interventions in countries or regions around the world.

WHO Global Health Observatory and Data Repository

http://apps.who.int/ghodata/
The Observatory provides health-related epidemiological and statistical information, as well as country and regional health summaries.

WHO Regional Office for Africa (WHO AFRO)

www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=7011
The Atlas of Health Statistics of the African Region report provides an overview of major health issues, prevalence data and health systems in Africa.

WHO/Regional Office for South-East Asia (WHO SEARO) publication catalogue (2005-2011)

www.searo.who.int/catalogue/2005-2011/index.htm
This searchable catalogue of publications from WHO SEARO includes extensive information on health, development, tuberculosis, nutrient deficiencies, malaria and emerging diseases in the South East Asian region.

WHO Vitamin and Mineral Nutrition information system

www.who.int/vmnis/en
The WHO Vitamin and Mineral Information Management System (VMNIS) (formerly the Micronutrient Deficiency Information System (MDIS)) includes three databases dealing with iodine deficiency disorders, vitamin A deficiency and anaemia in various countries and regions.

Other sources

Amnesty International

www.amnesty.org.au/refugees/
Access research and up-to-date news about countries of origin and transit, as well as case studies and personal testimonies from people of refugee background via this link.

The Australian Government – Refugee Review Tribunal Country Advice

www.mrt-rrt.gov.au/Country-Advice/Country-Advice/default.aspx
Refugee Review Tribunal country profiles include information on the geography and government of countries of origin of many refugee communities in Australia. Profiles often include information on ethnic and linguistic minorities, and timelines of events in regional and remote areas.

BBC Country Profiles (UK)

http://news.bbc.co.uk/2/hi/country_profiles/default.stm
This BBC resource allows users to select countries and regions within them to find profiles including history, timelines as well as political and economic background information.

Eldis Gateway to Development Information: Regional and Country Profiles

www.eldis.org/go/country-profiles
Eldis searches online media to provide the latest online documents and reports relating to health and other sectors of a particular country.

Ethnologue: Languages of the World

www.ethnologue.com/info.asp
Ethnologue is an encyclopaedic reference cataloguing the world's known living languages. The wb resource provides maps and a comprehensive listing of information about the world's languages, including lesser known languages.

EthnoMed

www.ethnomed.org
Includes information on cultural beliefs, medical, health and childrearing issues faced by recent arrivals including people of refugee background. Also information on clinical topics, client education and cross-cultural healthcare. Contains country profiles on many African countries.

European Country of Origin Information (ECOI) Network

www.ecoi.net/
Provides up-to-date country of origin information with a special focus on the needs of asylum case assessment. Access to information is facilitated by a comprehensive search tool.

The Internal Displacement Monitoring Centre

www.internal-displacement.org/
The Internal Displacement Monitoring Centre established by the Norwegian Refugee Council provides comprehensive information and analysis on internal displacement in 50 countries.

International Committee of the Red Cross

www.icrc.org/eng
Provides information and resources on the services and activities of the ICRC around the world including country reports.

International Crisis Group

www.crisisgroup.org/en.aspx
Provides regular and reliable updates and reports on countries in conflict situations, including reports on the impacts of conflict on civilians and human rights abuses.

UK Border Office – Country of Origin Information Service

www.ukba.homeoffice.gov.uk/policyandlaw/guidance/coi/
This resource provides up-to-date country of origin information based on extracts from a range of external sources such as news reports, NGO reports and official government documentation from the country of origin. Each country report includes sections on general health and mental health conditions in country.

US Department of State – Country Reports

www.state.gov/j/drl/rls/hrrpt/2010/index.htm
This link provides details of conflict and human rights conditions in 190 countries.

United States Committee for Refugees and Immigrants (USCRI) World Refugee Survey Country Reports (2009)

www.refugees.org/resources/refugee-warehousing/archived-world-refugee-surveys/2009-world-refugee-survey.html
A comprehensive biannual report that includes statistics and country updates. Links to refugee reports and information on resettlement in the United States including health resources aimed at a refugee audience, teaching tools and other resources.

Refugee health

Australian sites

Australian refugee health networks

www.refugeehealthnetwork.org.au/referral/National
Follow this link for website details of the refugee health network in your state or territory. Refugee health networks can provide you with resources, current information about refugee communities in your area and referral information.

Centre for Culture, Ethnicity and Health (CEH)

www.ceh.org.au
CEH provides information and resources related to the health needs of clients and communities from culturally and linguistically diverse backgrounds in Australia. Fact sheets, training modules and other information are available to download.

Centre for Multicultural Youth (CMY)

www.cmy.net.au/Issues
Provides information on the experiences and challenges faced by young migrants, and by young people of refugee background in Australia.

Diversity Health Institute Clearinghouse – Refugee health issues

http://203.32.142.106/clearinghouse/BrowseRefugee.htm
Provides topics relating to refugee health, and links to related information, publications and resources.

Forum of Australian Services for Survivors of Torture and Trauma (FASSTT)

www.fasstt.org.au
Provides information and links to organisations working with survivors of torture and trauma. Links to resources, research and publications available on their websites.

New South Wales Refugee Health Service

www.sswahs.nsw.gov.au/sswahs/refugee
Resources include community profiles, fact sheets, case studies, guides and multi-lingual resources.

Queensland Health

http://www.health.qld.gov.au/multicultural/
A gateway to multicultural community profiles, services, support tools, training events.
Includes country and health profiles for multicultural communities in Queensland

Refugee Health Queensland (RHQ)

www.health.qld.gov.au/multicultural/health_workers/refugee_hlth.asp
Provides documents and resources on refugee health in Queensland.

The Refugee Council of Australia

www.refugeecouncil.org.au
The peak body representing many Australian agencies working with refugees. It provides information and advocacy for Refugee and Humanitarian entrants in Australia. Information on the Humanitarian program and links to resources, position papers, and advocacy help kit.

Royal Australian College of General Practitioners (RACGP) Refugee and Asylum Seeker Health Resource Centre

www.racgp.org.au/refugeehealth
Provides resources for GP's including a large listing of journal articles (and links) from the John Murtagh Library, services and support agencies and a Tip Sheet for Treating Refugees and Asylum Seekers.

Royal Children's Hospital (Melbourne) Immigrant Health Service

www.rch.org.au/immigranthealth
This online resource provides guidelines for initial health assessment, catch-up immunisation, vitamins D and A, parasitic infections, hepatitis B, tuberculosis, iron deficiency and anaemia.

Victorian Transcultural Psychiatry Unit

www.vtpu.org.au/
Provides a bilingual dictionary for identifying bilingual doctors and services providers by name or language, translated mental health screening instruments, community profiles and other background materials.

International sites

Bridging Refugee Youth and Children's Services (BRYCS)

www.brycs.org/
This extensive site provides resources on cultural competency, general and mental health, family strengthening, and refugee community profiles to strengthen services to refugee children and their families.

Centres for Disease Control (USA)

www.dpd.cdc.gov/dpdx/
Provides information and identification of parasitic diseases.

The Cross Cultural Health Care Program (USA)

www.xculture.org
Provides information on the health beliefs, family life and maternal and child health practices of communities including Arab, Eritrean, Ethiopian, Oromo and Somali.

CulturedMed (USA)

www.sunyit.edu/culturedmed
Web site and a resource centre of print materials promoting culturally competent health care for refugees and immigrants. Provides practical information regarding culture and healthcare. It has bibliographies (including web links) by cultural group, and cultural aspects of many health issues including AIDS, dental care, diabetes, mental health and tuberculosis.

International Rehabilitation Council for Torture Victims

www.irct.org
Provides country reports and other resources including guides to the legal, medical and physical examination of torture and to psychological evidence of torture.

Minnesota Department of Health: Refugee Health

www.health.state.mn.us/divs/idepc/refugee
http://www.health.state.mn.us/divs/idepc/refugee/

Program for Monitoring Emerging Diseases, International Society for Infectious Diseases

www.promedmail.org
A global electronic reporting system for outbreaks of emerging infectious diseases and toxins. Provides up-to-date and reliable news and promotes communication among the international infectious diseases community. Email subscription available.

Refugee Health Information Network (RHIN) – Emerging Refugee Population Profiles and Health Information

www.rhin.org/EmergingPopulationsProvider.aspx
Health information and pre

Women's Commission for Refugee Women and Children

www.womenscommission.org
Provides information and reports on the situation of women and children refugees around the world. Includes guidelines on protection, obstetric care, AIDS and STIs in emergency.

Refugee community profiles in Australia

Department of Immigration and Citizenship (DIAC) Community Profiles

www.immi.gov.au/living-in-australia/delivering-assistance/government-programs/settlement-planning/community-profiles.htm
Community profiles provide information on key groups of entrants under Australia's Humanitarian Program. The Community Profiles have been developed to assist service providers to understand the backgrounds, experiences and likely settlement needs of new arrivals within these groups.The detailed profiles include Burmese, Congolese, Eritrean, Ethiopian, Liberian and Uzbek communities. Further profiles of refugee origin communities are being developed.

DIAC, Community Information Summaries

www.immi.gov.au/media/publications/statistics/comm-summ/index.htm
Presents a broad range of demographic and socio-economic characteristics on culturally and linguistically diverse (CALD) communities.

DIAC, Settlement Reporting Facility

www.immi.gov.au/settlement
Allows the general public to design custom reports on new arrivals to Australia, by visa code, gender, area of settlement, age and visa grant date.

Refugee Review Tribunal – Country Advice

www.mrt-rrt.gov.au/Country-Advice/Country-Advice/default.aspx

Translated health information

Beyondblue Emotional Health During Pregnancy and Early Parenthood

www.beyondblue.org.au/index.aspx?link_id=7.694
Booklet available in selection of languages including Arabic, Bosnian, Farsi/Persian, Tamil and Vietnamese.

Diversity Health Institute Clearing House Translated Information

www.dhi.gov.au/Clearinghouse/TranslatedInfo.htm
Provides health and settlement information in a wide range of languages. Includes feature on African communities with community profiles, statistical information, and translated health and settlement information.

ECHO Minnesota (US)

www.echominnesota.org/topics/health-and-safety
The ECHO channel has developed short health information videos in many languages. They are available to view by topic and language can be toggled using the language bar on the right hand side of the screen.

Eastern Health (Victoria) Cue Cards

www.easternhealth.org.au/services/cuecards/default.aspx
Cue Cards is a resource developed by Eastern Health Transcultural Service to assist health professionals to communicate with clients and carers who primary have English language difficulties. The printable cue cards cover instructions, family members, medical topics, time of day and religion.

Health information in other languages

Northumberland, Tyne & Wear (UK)

http://www.ntw.nhs.uk/pic/languages.php
A searchable database of health information in fifity lanauges that allows you to search via key word (e.g. diabetes) and language.

Health Translations Directory

www.healthtranslations.vic.gov.au
Victorian Government Health Information website, providing links to translated health resources from government departments, peak health bodies, hospitals, community health centres and welfare

Health Information Translations (USA)

www.healthinfotranslations.org/
Health Information Translations provides education resources in multiple languages for health care professionals and others to use in their communities. Resources are easy to read and culturally appropriate.

Agencies

Immunisation in your language

www.health.vic.gov.au/immunisation/factsheets/language.htm
The Victorian Department of Health has compiled a number of factsheets on immunisation and communicable diseases available in Arabic, Burmese, Dari, Dinka, Hakha Chin, Sinhalese, Somali, Thai and a number of other relevant community languages.

Immunization Action Coalition (USA)

www.immunize.org/vis

Marie Stopes

www.mariestopes.org.au/library/multilingual-resources
The Marie Stopes library offer plain English and multilingual resources on abortion, STIs, sexual health, contraception and health screening.

Medicare Information and explanation kits

www.medicareaustralia.gov.au/public/migrants/language/index.jsp
Medicare has developed information kits for new arrivals to Australia. The kits outline information about Australian health programs, including Medicare and the PBS.

Medline Plus (USA)

www.nlm.nih.gov/medlineplus/languages/languages.html
Search by language for information all sorts of health topics.

Medimate in Bilingual Booklets

www.nps.org.au/consumers/translated_health_information_about_medicines
Provides information and explanation about medicines. It covers prescription medicines, over-the-counter medicines and natural and herbal medicines.

Multilingual Appointment Card

www.communicate-health.org.uk/card
Creates an appointment card in over 30 languages.

Multicultural Centre for Women's Health

www.mcwh.com.au
This website provides information for immigrant and refugee women to help them make informed choices about sexual and reproductive health in 40 languages.

Mental Health in Multicultural Australia

www.mhima.org.au
Site includes links to translated mental health information sheets.

MyLanguage

www.mylanguage.gov.au/translated-information/health.html
A national portal for multicultural Australians to search and find information on the Internet in over 60 languages. Includes link to health and settlement information.

NSW Refugee Health Service

www.refugeehealth.org.au
This service provides translated information for refugees to assist them in accessing health care services. Click on Resources section and go to Multilingual.

NSW Multicultural Health Communication Service

www.mhcs.health.nsw.gov.au
Provides multilingual health resources, guidelines, protocols and policies. Over 450 publications on health in a wide range of languages, regularly updated. Access to resources by topic/language.

Dental Health Services Victoria

www.dhsv.org.au/oral-health-resources/translated-materials/
Dental Health Services Victoria (DHSV) has put together an online library of oral health information in Arabic, Chinese, English, Greek, Italian, Macedonian, Somali, Spanish, Turkish and Vietnamese that can downloaded online and used for health promotion purposes.

PapScreen Victoria

www.papscreen.org.au/resources/
Information on pap tests, HPV and cervical cancer available in a number of community languages. Multilingual posters to put up in your practice are also available via this link.

Queensland Health

www.health.qld.gov.au/multicultural/default.asp
Includes multilingual fact sheets, transcultural mental health multilingual resources including Cultural Diversity a Guide for Health Professionals.

Refugee Health Service, Auckland

www.refugeehealth.govt.nz
Provides multilingual information sheets about basic health issues for newly arrived refugees.

Selected Patient Information Resources in Asian Languages (SPIRAL)

http://spiral.tufts.edu/topic.html
Information on a wide range of health issues in Asian languages including Khmer, Vietnamese, Hmong, Thai and Chinese.

Stanford Health Library (US)

http://healthlibrary.stanford.edu/resources/foreign/
Links to health multilingual health resources from around the world including fact sheets, multilingual websites and posters.

U.S. Committee for Refugee and Immigrants – Health resource library (USA)

www.refugees.org/resources/for-refugees--immigrants/health/
Healthy living and eating information for newly settled refugees in the United States.

Victorian Transcultural Psychiatry Unit (VTPU)

www.vtpu.org.au
Includes the Directory of Translated Mental Health Information and training resources including the new DVD and Guidelines for working effectively with interpreters in a mental health setting. Also a list of translated mental health instruments for use by mental health professionals at www.vtpu.org.au/resources/translatedinstruments

Well Women

www.thewomens.org.au/MultilingualFactSheets
Provides multilingual women's health information.

Refugee and migrant health research

Canadian Collaboration for Immigrant and Refugee Health (CCIRH)

www.ccirh.uottawa.ca/eng/index.html
Based at the University of Ottowa, Canada, the CCIRH brings together health practitioners, policymakers and refugee community members to improve the health of immigrants and refugees. In 2011CCIRH collaborated with the Canadian Medical Association Journal to publish some refugee health screening guidelines for new arrivals to Canada. These guidelines provide detailed information on prevalence of particular diseases among newly resettling refugee cohorts, and on various screening and treatment regimens.

Centre for Culture, Ethnicity and Health

www.ceh.org.au
Provides information, training and resources related to the health needs of clients and communities from culturally and linguistically diverse backgrounds. Select resources available to download.

Monash University Primary Care Research Unit

www.med.monash.edu.au/general-practice/research/sapcru.html
Provides information, training and resources related to the health needs of clients and communities from culturally and linguistically diverse backgrounds, including refugee communities in Victoria and Australia. Select resources available to download.

Latrobe University Refugee Research Centre

www.latrobe.edu.au/larrc
Multi-disciplinary research centre to promote the health and well-being of refugee communities. Publications, articles and reports available to download. Refugee health bibliography also available.

University of New South Wales Centre for Refugee Research

www.crr.unsw.edu.au
An interdisciplinary centre based at the University of New South Wales providing research and innovative education programs. Provides reports and a range of information about refugee rights, law, policy and service provision, and useful refugee health related links.

Section 11:
Referral and further information



This section contains referral information (websites and phone numbers) for refugee health services and assistance agencies in each Australian State or Territory.

Services are listed under the following general categories. Please note that services may be categorised differently in each state/territory.

- Asylum seekers
- Child protection
- Community health
- Dental
- Disability
- Family planning
- Family violence
- Female genital mutilation
- General Practice divisions
- Hearing
- Immunisation
- Infectious diseases
- Interpreters/language services
- Legal centres
- Maternal and child health
- Mental health – adult
- Mental health – child and adolescent
- Multilingual and multicultural health resources
- Nutrition
- Older refugees
- Optometry
- Psychological support, counselling, torture and trauma
- Refugee and immigrant health
- Refugee health networks
- Settlement services (HSS contact, Migrant Resource Centres)
- Sexual assault
- Sexual health
- Other key services and resources

National services

Asylum seekers

Australian Red Cross Migration Support 03 9345 1800
www.redcross.org.au/migration-support.aspx
For information about the Asylum Seeker Assistance Scheme (ASAS) and Community Assistance Support (CAS)

Family tracing

Red Cross Tracing and Refugee Services

See www.redcross.org.au/tracing-and-restoration-of-family-links.aspx for contact details in each state and territory.
Includes tracing requests, Red Cross messages, health and welfare reports, international disaster enquiries, travel documents and certificates of captivity.

Hearing

Australian Hearing 02 9412 6800
www.hearing.com.au

Interpreter or language services

Translating and Interpreting Service (TIS) National 131 450
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/

TIS Doctors' Priority Line 1300 131 450
This interpreting service is free to all health practitioners and their staff when offering Medicare rebated services.

TIS National Client Code registration form
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm

On-site interpreter booking form
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/booking.htm

Telephone interpreter pre-booking form
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/_pdf/request-pre-booked-telephone-interpreter.pdf

Mental health

Mental Health in Multicultural Australia 07 3167 8306
www.mhima.org.au

Settlement

Humanitarian Settlement Service (HSS) providers
National General Inquiry Service 131 881
HSS services are delivered by service providers contracted to DIAC. A list of current HSS providers can be found at www.immi.gov.au/living-in-australia/settle-in-australia/find-help/hss/hss_service_providers.pdf

Australian Capital Territory

Asylum seekers

Australian Red Cross Asylum Seekers Assistance Scheme (ASAS) and Community Assistance Support (CAS)
02 6234 7600
F: 02 6232 5115
actinfo@redcross.org.au

Child protection services

Care and Protection Services (24 hours) 1300 556 729
F: 02 62050641
childprotection@act.gov.au

Child at Risk Assessment Unit 02 6244 2712

Community health services

Central contact number and intake line 02 6207 9977
Including referral for physiotherapy, dietitian, dental and community nursing
F: 02 6205 2611
chiintake@act.gov.au

Dental services

Refugee dental program 02 6205 5060
(dental health care in first 12 months in Australia)
F: 02 6205 0984

DENTAL CLINICS

Civic 02 6205 0977

Belconnen 02 6205 1541

Phillip 02 6205 1463

Tuggeranong 02 6205 2768

Disability services

Disability ACT 02 6207 1086
disabilityACT@act.gov.au

Family planning

Sexual Health and Family Planning ACT Clinic 02 6247 3077
F: 02 6257 5710
www.shfpact.org.au

Education Services SHFPACT 02 6247 3018

Family violence

Domestic Violence Crisis Service (24 hours) 02 6280 0900
F: 02 6280 9777
www.dvcs.org.au
admin@dvcs.org.au

Relationships Australia (24 hours) 02 6122 7100
F: 02 6122 7199
enquiries@car.relationships.com.au

Female genital mutilation

Women's Health Service 02 6205 1078
F: 02 6207 0143

Hearing

Australian Hearing 131 797

Australian Government Hearing Services Program
1800 500 726

Immunisation

Health Protection Service Immunisation Enquiry Line
02 6205 2300

Torture and trauma services

Companion House Assisting Survivors of Torture and Trauma
02 6251 4550
F: 02 6251 8550
www.companionhouse.org.au
info@companionhouse.org.au

Infectious diseases

Infectious Diseases Department TCH
02 6244 2105 F: 02 6244 4646

ACT Health Communicable Disease and Infection Control
02 6205 2300 F: 02 6205 0711

Thoracic Unit TCH (TB Screening) 02 6244 2066
F: 02 6244 2604

Interpreters/language services

Translating and Interpreting Service (TIS) National 131 450

TIS Doctors' Priority Line 1300 131 450
(normal wait time 3 minutes)

TIS National Client Code registration form
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm

TIS interpreter booking forms
On-site www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/booking.htm
Pre-booked telephone interpreterwww.immi.gov.au/living-in-australia/help-with-english/help_with_translating/_pdf/request-pre-booked-telephone-interpreter.pdf

Migrant Health Unit 02 6205 3333 F: 02 6205 5035

Legal centres

Legal Aid Office ACT 02 6243 3471 F: 02 62433436
legalaid@legalaidact.org.au

Welfare Rights and Legal Centre 1800 445 665
wrlc@netspeed.com.au

Women's Legal Centre Inc 02 6257 4499
www.womenslegalact.org

Maternal and child health

Maternal and Child Health Clinics (Community Health Intake)
02 6207 9977

Mental health services (adult)

Mental Health Crisis, Assessment and Treatment (24 hours)
1800 629 354
F: 02 6205 1978
E: public.affairs@act.gov.au

Mental health services (child and adolescent)

Child and Adolescent Mental Health Service 02 6205 1971
F: 02 6205 2627

Multilingual and multicultural health resources

Migrant Health Service 02 6298 9233

Nutrition

ACT Health Community Health Intake 02 6207 9977

Optometry

Most optometrists bulk bill.

Psychological support and counselling

Companion House 02 6251 4550 F: 02 6251 8550
info@companionhouse.org.au

Refugee and immigrant health services

Companion House Medical Service 02 6251 4550
F: 02 6251 8550
info@companionhouse.org.au

The Canberra Hospital 02 6244 2222

Calvary Hospital 02 6201 6111

Settlement services

Migrant & refugee settlement services (MARSS) 02 6248 8577
www.marss.org.au

Centacare 02 6295 4320

Multilingual Centre Queanbeyan 02 6297 6110

Youth services

Multicultural Youth Service 02 6247 1794

Sexual assault

Canberra Rape Crisis Centre 02 6247 2525

New South Wales

Asylum seekers

Asylum Seekers Centre 02 9361 5606
F: 02 9331 6670
(Mon–Thurs, 9.00am–4.00pm)
38 Nobbs Street, Surry Hills
www.asylumseekerscentre.org.au

NSW Branch, Australian Red Cross Asylum Seekers Assistance Scheme (ASAS) and Community Assistance Support (CAS)
02 9229 4111
Free call 1800 812 028

House of Welcome 02 9727 9290
(Mon–Thurs, Drop-in centre 10am–3pm, Office 9am–4pm)
140 Wattle Avenue Carramar NSW 2163
www.houseofwelcome.com.au
office@ houseofwelcome.com.au

Jesuit Refugee Service (JRS) Australia
02 9356 3888
www.jrs.org.au
While JRS does not provide any material aid at present, JRS work closely with the Asylum Seeker Centre

Amnesty International Australia Refugee Network
02 8396 7629
Level 1, 79 Myrtle Street, Chippendale NSW 2008
www.amnesty.org.au/nsw/
nswrefugeeteam@amnesty.org.au (NSW Refugee Network)
refugee_team@amnesty.org.au (Refugee casework team)

Amnesty International's Refugee Network conducts casework for asylum seekers. They are able to provide detailed country information pertinent to the particular claims of asylum seekers and write a report into the situation an asylum seeker will face if returned to their country. The Refugee Network can provide referral to the Refugee Advice and Casework Service (RACS).

Bridge for Asylum Seekers Foundation (BSAF) Sydney
0418 261 160

BASF is a coalition of churches, human rights groups, unions, political representatives, and individuals. It provides living allowances to asylum seekers on Bridging Visa Es or released under Habeas Corpus orders who have no adequate means of survival.
www.asylumseekersfoundation.com
asylumseekersfoundation@bigpond.com

The Sisters of Mercy – Community Links Project 02 9564 1911
1 Thomas Street, Lewisham NSW 2049
www.mercy.org.au/mercyworks
mercyworks@mercy.org.au

The Sisters of Mercy work with asylum seekers in the community. The Sisters support vulnerable families to advocate for them at appointments, assist them with Department of Housing, doctors' appointments, Centrelink, to link up with mainstream services, and social community groups. They also provide referral to local material aid initiatives.

Marist Youth Care 02 9672 9200
F: 02 9672 9300
36 First Avenue, Blacktown NSW 2148
info@maristyc.com.au

Community Detention

Uniting Care Burnside Central Office
02 9768 6866
13 Blackwood Place North Parramatta NSW 2151
mail@burnside.org.au

St Vincent De Paul Migrant and Refugee Team
02 9560 8666
migrant.refugee@vinnies.org.au

Child protection services

DOCS HelpLine 132 111 or TTY 1800 212 936
(for the hearing impaired) (24 hours)

Kids Help Line 1800 55 1800

Child Abuse Prevention Service 02 9716 8000
1800 688 009
www.childabuseprevention.com.au

Community health services

Search directory for: community health service/centre:
www2.health.nsw.gov.au/services/Default.cfm

Dental services

Search directory for: oral health services:
www2.health.nsw.gov.au/services/Default.cfm

Northern Sydney and Central Coast 1300 789 404

South Eastern Sydney 1300 134 226

Illawarra Shoalhaven 1300 369 651

Sydney and South Western Sydney 02 9293 3333

Western Sydney 02 9845 6766

Nepean Blue Mountains 1300 739 949

Murrumbidgee and Southern NSW 1800 450 046

Far West and Western NSW 1300 552 626

Hunter New England, Northern NSW and Mid North Coast
1300 651 625
Westmead Refugee Dental Clinic (Sydney West area only)
02 8778 0770

Disability services

Multicultural Disability Advocacy Association (MDAA)
Free call 1800 629 072
Head Office 02 9891 6400
(Mon–Fri, 9am–5pm)
Online directory of services for from non-English speaking backgrounds living with a disability and their carers:
www.mdaa.org.au

Emergency accommodation

Youth Emergency Accommodation Line (for those over 18 years)
Sydney 02 9318 1531
Outside Sydney 1800 424 830

Non-English Speaking Housing (NESH) Women's Scheme
(women and children) 02 9726 7969 F: 02 9726 9039
(Mon-Fri, 9am–5pm)
www.nesh.org.au/NS/default.aspx
nesh@nesh.org.au

Homeless Persons Information Centre (men, women, families)
1800 234 566

Family planning

FPA Health NSW 02 9716 6099
www.fpnsw.org.au
F: 02 8752 4392

Family violence

DOCS Domestic Violence Line (24 hours) 1800 656 463
Crisis assistance, counselling and refuge information for women who are experiencing violence from their partner or ex-partner

National Domestic Violence and Sexual Assault Line (24 hours)
1800 200 526

Parent Line (24 hours) 1300 1300 52

Relationships Australia 1300 364 277
All types of counselling for all types of family relationships

Female genital mutilation

NSW Education Program on FGM 02 9840 3800
Resources and education for service providers to women with FGM
www.dhi.gov.au/fgm/fgm/default.aspx

Family Planning NSW Multicultural Service 02 9754 1322
Women's Sexual and Reproductive Health for people from CALD backgrounds

General practice divisions

General Practice NSW 02 9239 2900
www.gpnsw.com.au

Hearing

Australian Government hearing services program 131 797
www.hearing.com.au/info-for-gps

New South Wales Deaf Society
www.deafsocietynsw.org.au/
Parramatta Office 02 8833 3600 or
02 8833 3691(for hearing impaired)
Suite 401, Level 4, 9 Phillip St, Parramatta NSW 2150
(Walk-in times: Mon and Wed, 9am–12 noon then 1pm–4pm,
Fri, 1pm–4pm. No appointment needed)

The Shepherd Centre 1800 020 030
http://shepherdcentre.org.au/
enquiries@shephardcentre.org.au

Immunisation

Immunise Australia Information Line 1800 671 811
www.immunise.health.gov.au/

Infectious diseases

PUBLIC HEALTH ASPECTS

Public Health Unit
www2.health.nsw.gov.au/services/Default.cfm

Contact your regional Public Health Unit as per above (or see below)

Ask for public health officer on call at:

Albury Office (Albury Base Hospital) 02 6080 8900

Bathurst Office 02 6339 5601 or 0428 400 526

Goulburn Office (Albury Base Hospital) 02 6080 8900

Broken Hill Base Hospital 08 8080 1333 or 0417 685 259

Dubbo Base Hospital 02 6885 8666

Newcastle Office (John Hunter Hospital) 02 4924 6477

Tamworth Office (Tamworth Base Hospital) 02 6764 8000

Matraville Office 02 9311 2707

Port Macquarie Office Communicable Diseases
132 222 and ask for pager 397635
Environmental Health dial 132 222 Ask for Pager 314857 or
0417 244 966/0407 904 208

Hornsby Hospital 02 9477 9123

Gosford Hospital 02 4320 2111 (ask for public health nurse)

Randwick Office (Prince of Wales Hospital) 02 9382 2222

Wollongong Hospital 02 4222 5000

Camperdown Office (including Liverpool) (Royal Prince Alfred Hospital) 02 9515 6111

Penrith Office (Westmead Hospital) 02 9845 5555

Parramatta Office (Westmead Hospital) 02 9845 5555

CLINICAL ASPECTS

Microbiology or Infectious Diseases Department of:

John Hunter Hospital 02 4921 4000

Liverpool Hospital 02 9828 5124

Royal Prince Alfred Hospital 02 9515 8278

Royal North Shore Hospital 02 9926 8470

St Vincent's Hospital 02 8382 9196

The Children's Hospital at Westmead 02 9845 3270

Institute of Clinical Pathology & Medical Research 02 9845 6600

Wollongong Hospital 02 4222 5335

Tuberculosis chest clinics

www.health.nsw.gov.au/PublicHealth/Infectious/TB/chest_clinics.asp

METROPOLITAN CLINICS

SYDNEY SOUTH AND SOUTH WEST

Canterbury Hospital 02 9787 0946

Concord Hospital 02 9767 5675

Royal Prince Alfred Hospital 02 9515 8846

NORTHERN SYDNEY & CENTRAL COAST

Hornsby Hospital 02 9477 9318

Manly Hospital 02 9976 9542

Royal North Shore Hospital 02 9926 7905

Gosford Hospital 02 4320 3388

SOUTH EASTERN SYDNEY & ILLAWARRA

Prince of Wales Hospital 02 9382 4643

St George Hospital 02 9113 2430

St Vincent's Hospital 02 8382 3876

Sydney Hospital 02 9382 7535

Wollongong Hospital 02 4253 4138

SYDNEY WEST

Parramatta Health Service 02 9843 3110

Nepean Hospital 02 4734 2536

RURAL CLINICS

HUNTER & NEW ENGLAND

John Hunter Hospital 02 4921 3372

Taree Health Clinic 02 6592 9315

Tamworth Community Centre 02 6767 7787

NORTH COAST

Lismore Population Health 02 6620 2280

Coffs Harbour Health Campus 02 6656 7855

Port Macquarie Health Centre 02 6588 2755

GREATER SOUTHERN

Queanbeyan Population Health 02 6124 9934

Bega Community Health Centre 02 6492 9620

Cooma Community Health Centre 02 6124 9934

Goulburn Community Health Centre 02 4827 3913

Narooma Community Health Centre 02 4476 2344

Queanbeyan Community Health Centre 02 6298 9233

Young Mercy Care Centre 02 6382 1111

GREATER WESTERN

Broken Hill Population Health 08 8080 1510

Interpreters/language resources

Translating and Interpreting Service (TIS) National 131 450

TIS Doctors' Priority Line 1300 131 450
(normal wait time 3 minutes)

TIS National Client Code registration form
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm

TIS interpreter booking forms
On-site www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/booking.htm
Pre-booked telephone interpreterwww.immi.gov.au/living-in-australia/help-with-english/help_with_translating/_pdf/request-pre-booked-telephone-interpreter.pdf

NSW Multicultural Health Communication Service
02 9816 0347
www.mhcs.health.nsw.gov.au

Centrelink Multilingual Service 131 202
www.centrelink.gov.au/internet/internet.nsf/services/multilingual_call.htm
Phone number is only for people speaking languages other than English

Legal centres

Refugee Advice and Casework Service 02 9114 1600
F: 02 9114-1794
www.racs.org.au
admin@racs.org.au

Immigration Advice and Rights Centre
Telephone advice 02 9262 3833 F: 02 9299 8467
Face-to-face appointment booking 02 9279 4300
www.iarc.asn.au
iarc@iarc.asn.au

Legal Aid NSW 02 9219 5000 (admin) or
1300 888 529 (telephone advice)
www.legalaid.nsw.gov.au
323 Castlereagh Street, Sydney NSW 2000

Women's legal services Sydney 02 9749 4433
Rural 1800 801 501 F: 02 9749 4433
www.womenslegalnsw.asn.au
Free legal advice, information and education for women.
(Mon–Fri, 9am–1pm and 2pm–4.30pm)

National Association for Community Legal Centres
02 9264 9595 F: 02 9264 9594
Womens_NSW@clc.net.au
www.naclc.org.au
This is a directory for all community legal centres.

Maternal and child health

Early Childhood Centres
For a list of centres see
www.bubhub.com.au/directory/find/early-childhood-health-centres-sydney
www.bubhub.com.au/directory/find/early-childhood-health-centres-nsw-regions

NSW Department of Health
Early Childhood Health centres provide baby check-ups, parenting courses, breastfeeding and baby feeding help, childhood immunisation clinics and specialist services. Most of these services are offered free of charge to Sydney residents.

Parenting Hotlines
(24 hour service for parents needing urgent advice)
Karitane 1300 227 464
Tresillian 02 9787 0855

Healthdirect Australia pregnancy, birth & baby line
1800 882 436

Australian Breastfeeding Association Help Line 02 8853 4999
www.breastfeeding.asn.au

Families NSW 1800 789 123
www.families.nsw.gov.au/

Women's Health

Women's Health Centres 02 9560 0866 F: 02 9560 2887
www.whnsw.asn.au/centres.htm
info@whnsw.asn.au

Nutrition

Community Nutritionists
www2.health.nsw.gov.au/services/Default.cfm
Search directory for: public hospitals and then call and ask for a community nutritionist

Fairfield Refugee Nutrition Program 02 8778 0770
www.refugeehealth.org.au

Older refugees

Commonwealth Respite and Carelink Centre 1800 200 422 or 1800 059 059 (afterhours)
www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Culturally and linguistically diverse people-3

Information about culturally appropriate services for older Australians and their carers.

Optometry

VisionCare NSW 02 9344 4122 or 1800 806 851 (non-metropolitan callers)
www.visioncarensw.com.au

The program organises and assists in the delivery of low cost vision care services and optical appliances to financially disadvantaged members of the community. This program is not available in rural areas.

Psychological support and counselling

STARTTS (Sydney) 02 9794 1900 F: 02 9794 1910
www.startts.org.au
startts@sswahs.nsw.gov.au

STARTTS also has offices in Liverpool, Auburn, Blacktown, Newcastle and Coffs Harbour and provides services from different outreach locations across Sydney and NSW.

Lifeline 131 114
www.lifeline.org.au

Transcultural Mental Health Centre 02 9840 3800
F: 61 2 9840 3755
www.dhi.gov.au/tmhc

Salvo Crisis Line 02 8736 3292
www.salvos.org.au/need-help/family-and-personal-issues/telephone-counselling.php

Multicultural Problem Gambling Service for NSW 02 9840 3800
F: 61 2 9840 3755
www.dhi.health.nsw.gov.au/mpgs/mpgs/default.aspx

Refugee health clinics

NSW Refugee Health Service 02 8778 0770
F: 61 2 8778 0790
(Mon–Fri, 8.30am–5pm)
Referrals and enquiries about clinics available on
www.sswahs.nsw.gov.au/sswahs/refugee
refugeehealth@swsahs.nsw.gov.au

The NSW Refugee Health Service (RHS) currently runs refugee health assessment clinics one day per week in Liverpool, Blacktown and Auburn, and monthly clinics in Fairfield and Mt Druitt. Medicare cards are not essential but referral options for individuals who are Medicare ineligible may be limited.

NSW Refugee Health Service through its Refugee Health in General Practice Project offers a comprehensive training program on refugee health to assist GPs to enhance their practice and provision of patient care.

Sydney Children's Hospital Randwick Refugee Child Health clinic 029382 8472 or 02 9382 8189

Westmead Children's Hospital Health Assessments for Refugee Kids (HARK) 02 9845 2525

Refugee Paediatric Clinic at Liverpool Hospital 02 9828 4844

Refugee Youth Health Clinic (Fairfield/Liverpool Youth Health Service) 02 8717 1717

Coffs Harbour Refugee Assessments 02 6656 7676

HUNTER NEW ENGLAND REFUGEE HEALTH CLINIC

Uralla Community Health Centre 02 6776 1205

Wallsend Community Health 02 4924 6412

John Hunter Children's Hospital 02 4921 3000

Wagga Wagga Refugee Health Assessment Clinic 02 6923 3111

Settlement services

HSS – Humanitarian settlement services
There are six HSS contract areas in NSW:
Central and South West Sydney, North West Sydney and Western NSW, Illawarra, Hunter, North Coast and Riverina.

SYDNEY

SSI – Settlement Services International 02 8071 1050
F: 9648 1225
www.ssi.org.au

SSI provides all HSS services in Central and South West Sydney, and North West Sydney and Western NSW Contract Regions, excluding accommodation services

Resolve FM 02 9648 1207 F: 02 9648 3207

Resolve FM provides accommodation services only, in the Central and South West Sydney, and North West Sydney and Western NSW Contract Regions

HUNTER REGION

Navitas Newcastle 02 4904 2800 F: 02 4926 4890
www.navitasenglish.com/hss.html
hsshunter@navitas.com

ILLAWARRA REGION

Navitas Wollongong 02 4254 7400 F: 02 4226 2653
www.navitasenglish.com/hss.html
hssillawarra@navitas.com

NORTH COAST REGION

Anglicare North Coast 02 9895 8000
www.anglicare.org.au/our-services/migrant-refugee-services/ihss

RIVERINA REGION

The Trustees of the Society of St Vincent De Paul (NSW) Consortium 02 6971 7175
www.vinnies.org.au/migrant-and-refugee-national

Migrant resource centres

Auburn Diversity Services 02 9649 6955
www.auburndiversity.org.au

Sydney West multicultural services 02 9621 6633
www.sydwestmsi.org.au/

Sydney Multicultural Community Services (Eastern suburbs) 02 9663 3922
www.sydneymcs.org.au/

Metro migrant resource centre (Canterbury, Bankstown area) 02 9789 3744
www.metromrc.org.au/

Cabramatta community centre/ Fairfield migrant resource centre 02 9727 0477
http://cabracc.org.au/fmrc/index.htm

The Hills Holroyd Parramatta migrant resource centre 02 9687 9901
www.thhpmrc.org.au

Liverpool migrant resource centre 02 9601 3788
www.lmrc.org.au

Macarthur Diversity Services Initiative 02 4627 1188
www.mdsi.org.au

St George Migrant Resource Centre 02 9597 5455
www.sgmrc.org.au

Illawarra multicultural services 02 4229 6855
www.ims.org.au

NEWCASTLE AND HUNTER REGION

Northern settlement services 02 4969 3399
www.nsservices.com.au/

Sexual assault

Search directory for: sexual assault service:
www2.health.nsw.gov.au/services/Default.cfm

NSW Rape Crisis Centre 1800 424 017
www.nswrapecrisis.com.au

Royal North Shore Hospital 02 9926 7580

Royal Prince Alfred Hospital 02 9515 9040

Liverpool Hospital 02 9828 4844 (during business hours to speak to a Sexual Assault Counsellor) or call the hospital switchboard on 02 9828 3000 for emergencies or after hours)

Westmead Hospital 02 9845 7940

Newcastle Sexual Assault Service 02 4924 6333

Wollongong Hospital 02 4222 5408
(after hours ask for Sexual Assault Counsellor on call)

Westmead Hospital Child Protection Unit
(children under 16 years of age) 02 9845 2434

Sydney Child Protection Unit (children under 16 years of age)
02 9382 1412

St George Hospital 02 9113 2494

Sexual health

Multicultural HIV/AIDS and Hepatitis C Service
www.multiculturalhivhepc.net.au
Bicultural co-workers and information 02 9515 5030
or free call (NSW Country) 1800 108 098

Sexual Health Services – Sexual Health Info Line 1800 451 624
www.health.nsw.gov.au/sexualhealth/getting_tested.html

Youth health

Search directory for youth health services:
www2.health.nsw.gov.au/services/Default.cfm

Drug and alcohol

Drug and Alcohol Multicultural Education Centre (DAMEC)
02 9699 3552 F: 02 9699 3131
www.damec.org.au
admin@damec.org.au

Refugee Council of Australia 02 9211 9333
F: 02 9211 9288
www.refugeecouncil.org.au
info@refugeecouncil.org.au

Mercy Refugee Service 02 9564 1911 F: 02 9550 9683
www.mercyworks.org.au/programs/refugee_services.html
mercyworks@mercy.org.au

Immigrant Women's Speakout Association 02 9635 8022
F: 02 9635 8176
(Mon–Fri, 9.30am–5.00pm)
www.speakout.org.au
women@speakout.org.au

Learning and professional development

NSW Refugee Health Service 02 8778 0770
F: 02 8778 0790
(Mon–Fri, 8.30am–5.00pm)
www.refugeehealth.org.au
refugeehealth@swsahs.nsw.gov.au

NSW Refugee Health Service through its Refugee Health in General Practice Project offers a comprehensive training program on refugee health to assist GPs to enhance their practice and provision of patient care.

Northern Territory

Asylum seekers

Australian Red Cross Asylum Seekers Assistance Scheme (ASAS) and Community Assistance Support (CAS)
08 8945 3655

Child protection services

Central Notification for NT 1800 700 250

Child Protection Services:
Alice Springs 08 8955 6001
Casuarina 08 8922 7111
Palmerston 08 8999 4789

Community health centres

Alice Springs Community Health Centre 08 8951 6711

Casuarina Community Care Centre 08 8922 7301

Darwin Community Care Centre 08 8999 2876

Palmerston Community Care Centre 08 8999 3344

Dental services

Alice Springs Community Dental Clinic 08 8951 6713

Darwin Dental Clinic 08 8922 6404

Palmerston Dental Clinic 08 8999 3314

Disability services

Central Australia 08 8951 6744

Darwin 08 8922 7424

Darwin Liaison Office 08 8951 5177

Family planning

Family Planning Welfare NT 08 8948 0144
Regional areas 1800 193 121

Family violence

CRISIS ASSISTANCE

Northern Territory Police 000 and 08 8927 8888

NT Police Domestic Violence Unit 08 8948 0110

Emergency accommodation

Anglicare Youth Housing Program Darwin 08 8985 0000

Casey House (youth) 08 8948 2044

Catherine Booth House (single women) 08 8981 5928

Christian Outreach Centre (families) 08 8947 0633

Dawn House (women and children) 08 8945 1388

Oakley House (young women) 08 8945 3774

Palmerston Family Crisis Accommodation and Support Service 08 8932 9155

Sisters of Charity (women and children – no boys over 8 years) 08 8981 3428

Stanley House (single young women) 08 8945 3774

Red Shield Hostel (families) 08 8981 5994

Counselling and support

DARWIN

Anglicare Community Settlement Scheme 08 8952 6048

Dawn House 08 8945 1388

Domestic Violence Legal Help 08 8941 7940

ALICE SPRINGS

Domestic Violence Advice Service 08 8952 1391

Catherine House 08 8952 6048

Women's Shelter 08 8952 6075

Domestic violence counselling services

Alice Springs 08 8952 6048

Darwin 08 8945 6200

East Arnhem Region 08 8987 0428

Jabiru 08 8979 3154

Katherine 08 8972 1733

Tennant Creek 08 8962 1011

Female genital mutilation

Guidelines: Female Genital Mutilation A resource manual for community health professionals, Northern Territory Department of Health and Community Services, Darwin
Women's Health Strategy Unit 08 8985 8018

Hearing

Deaf NT
www.deafau.org.au/info/ntcdp.php

Immunisation

Alice Springs Community Health Centre 08 8951 6711

Casuarina Community Care Centre 08 8922 7301

Darwin Community Care Centre 08 8999 2876

Infectious diseases

Hospital Infectious Disease Services and patient care (inpatient/outpatient)

Royal Darwin Hospital clinical advice to GPs (physician on call)
08 8922 8888

Royal Darwin Hospital TB/Chest Clinic 08 8922 8804
Public Health aspects of infectious disease control

Centre for Disease Control– Territory Health Services
08 8922 8044

Interpreters/language services

Translating and Interpreting Service (TIS) National 131 450

TIS Doctors' Priority Line 1300 131 450
(normal wait time 3 minutes)

TIS National Client Code registration form
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm

TIS interpreter booking forms
On-site www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/booking.htm
Pre-booked telephone interpreterwww.immi.gov.au/living-in-australia/help-with-english/help_with_translating/_pdf/request-pre-booked-telephone-interpreter.pdf
For Territory health services and community based organisations

Fee for Service for GPs
Northern Territory Interpreting & Translating Service (NTITS)
1800 676 254 (Mon–Fri, 8.30am–4pm)

Legal centres

Top End Women's Legal Service 08 8941 9989

Darwin Community Legal Service 08 8982 1111

Central Australian Women's Legal Service 08 8952 4055

Katherine Women's Information and Legal Service 08 8972 1712

Australian Red Cross: International Humanitarian Law
08 8924 3931

Northern Territory Legal Aid Commission 08 8999 3000

Maternal and child health

Alice Springs 08 8951 6711

Casuarina 08 8922 7301

Karama 08 8927 7532

Katherine 08 8973 8570

Nightcliff 08 8948 9088

Palmerston 08 8999 3344

Mental health services

Darwin Top End Mental Health Services
Inpatient Services 08 8922 7800

Tamarind Centre 08 8999 4988

Alice Springs 08 8951 7710

Nutrition and physical activity

Alice Springs 08 8951 6731

Alice Springs Hospital 08 8951 7783

Darwin 08 8999 2953

Royal Darwin Hospital 08 8922 8727

Optometry

Most optometrists bulk bill see White Pages
www.whitepages.com.au

Psychological support and counselling

Melaleuca Refugee Centre Darwin 08 8985 3311

Urban Mental Health Services (Emergency Assessment Service) 08 8999 4988

Community mental health teams

Alice Springs 08 8951 7710

Darwin 08 8999 4988

Katherine 08 8973 8722

Nhulunbuy 08 8987 0412

Tennant Creek 08 8962 4300

Refugee/immigrant health services

Royal Darwin Hospital 08 8922 8888

Refugee Clinic 08 89455888

TB Chest Clinic 08 8922 8522

Settlement services

DARWIN

Melaleuca Refugee Centre 08 8985 3311

Anglicare Community Settlement Services 08 8985 0000

Salvation Army (African Specific) 08 8945 1947

Multicultural Council of the Northern Territory (MCNT) 08 8945 9122

ALICE SPRINGS

Migrant Resource Centre 08 8952 8776

Sexual assault

DARWIN

Sexual Assault Referral Centre (24 hours) 08 8922 7156

Ruby Gaea House (Darwin Centre against Rape) 08 8945 0155

ALICE SPRINGS
Sexual Assault Referral Centre 08 8951 5880

KATHERINE
Centacare 08 8971 0777

Queensland

Asylum seekers

Australian Red Cross Asylum Seekers Assistance Scheme (ASAS) and Community Assistance Support (CAS)
07 3367 7222
F: 07 3367 7444
Services available Cairns, Gold Coast, Rockhampton, Townsville
1300 554 419
www.redcross.org.au/migration-support.aspx

Refugee Claimants Support Centre 07 3357 9013
F: 07 3357 9019
(Mon, Tues, Thurs)
www.refugees.org.au
refugee.voladmin@uccommunity.org.au

Romero Community Centre 07 3013 0100 F: 07 3846 3910
www.romerocentre.org.au
admin@romerocentre.org.au

Child protection services

Department of Communities (Child Safety Services)
1800 811 810 or 07 3224 8045
www.childsafety.qld.gov.au
info@childsafety.qld.gov.au

Child Safety After Hours Service Centre
07 3235 9999 or 1800 177 135

Western Districts Out of Home Care 07 3278 8007
F: 07 3278 8550
www.wdohc.org.au
intake@wdohc.org.au

Provides support for foster carers and children in out of home care.

Community health services

Queensland Health 13 HEALTH (13 43 25 84)
www.health.qld.gov.au/services

If you require help to locate a service, call and staff will assist you with your query 24 hours a day, 7 days a week.

Dental services

Full list of clinics available at:
www.health.qld.gov.au/oralhealth/services/dental_clinics.asp

South Brisbane Dental Hospital 07 3240 1444

Metro North Royal Brisbane Call Centre 1300 650 002

Logan Central Dental Clinic 07 3290 8933

Gold Coast Oral Health (emergency dental care)
07 5526 3572 or 1300 300 850

Toowoomba Dental Clinic 07 4616 6436

Cairns Dental Clinic 07 4050 8711

Townsville Call Centre 1300 300 850

Disability services

Amparo Advocacy Inc 07 3369 2500
www.amparo.org.au
amparo@amparo.org.au

Family planning

Family Planning Queensland 07 3250 0240
F: 07 3250 0292
www.fpq.com.au

Cairns 07 4051 3788

Rockhampton 07 4927 3999

Toowoomba 07 4632 8166

Townsville 07 4273 8184

Family violence

Women's DV Connect Line (24 hours) 1800 811 811
www.dvconnect.org

Men's DV Connect Line (24 hours) 1800 600 636

Immigrant Women's Support Service (IWSS) 07 3846 3490

Spiritus Counselling and Education Services 1300 114 397
(Family relationships counselling – domestic violence support for men only)

Female genital mutilation

Family Planning Queensland FGM Education Project
07 3250 0240 F: 3250 0292
www.fpq.com.au

Hearing services

For a list of public and private audiology services please refer to:
www.audiology.asn.au/pdf/service/asa-qld.pdf

Audiology Society of Australia 03 9416 4606
F: 03 9416 4607
info@audiologyasn.au

Office of Hearing Services (Department of Health and Ageing) for access to Hearing Services Vouchers
02 6289 1555 or 1800 020 103
www.health.gov.au/internet/main/publishing.nsf/Content/health-hear-contacts-clsline.htm

Australian Hearing 13 17 97
www.hearing.com.au

Immunisation

www.health.qld.gov.au/cchs/immunisation.asp

Brisbane Southside Public Health Unit 07 3000 9148

Brisbane Northside Public Health Unit 07 3624 1111

Queensland Health Immunisation Program (QHIP) 07 3328 9888

Brisbane City Council Clinics 07 3403 8888
www.brisbane.qld.gov.au/community-support/immunisation/index.htm

Infectious diseases

Queensland Tuberculosis Control Centre, Princess Alexander Hospital 07 3896 3955 or 3896 3963

Prince Charles Hospital 07 3139 4000

Royal Brisbane and Women's Hospital Infectious Disease Unit 07 3636 8111

Biala Community Health Centre 07 3837 5633

Cairns TB Health Service 07 4050 6266

Population Health Communicable Disease Unit 07 3234 1155

See also **local public health units**:

Brisbane Northside 07 3624 1111

Brisbane Southside 07 3000 9148

Darling Downs (Toowoomba) 07 4631 9888

Gold Coast 07 5668 3700

Logan 07 3412 2989

West Moreton (Ipswich) 07 3413 1200

Cairns 07 4226 5555

Rockhampton 07 4920 6989

Townsville 07 4753 9000

Interpreters/language services

Translating and Interpreting Service (TIS) National 131 450

TIS Doctors' Priority Line 1300 131 450
(normal wait time 3 minutes)

TIS National Client Code registration form
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm

TIS interpreter booking forms
On-site
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/booking.htm
Pre-booked telephone interpreter
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/_pdf/request-pre-booked-telephone-interpreter.pdf

FEE FOR SERVICE

ONCALL Interpreters and Translators Agency 07 3018 0333
brisbane@oncallinterpreters.com

QITS (Queensland Interpreting and Translating Service)
07 3835 3777
mail@qits.com.au

Legal services (free legal advice)

Refugee and Immigrant Legal Service (RAILS) 07 3846 3189
www.rails.org.au

Women's Legal Service 07 3392 0670
Outside Brisbane 1800 677 278
www.wlsq.org.au

Caxton Legal Centre 07 3214 6333 F: 3846 7483
www.caxton.org.au
caxton@caxton.org.au
Legal Aid 1300 651 188

Cairns Community Legal Centre 07 4031 7688

Townsville Community Legal Service 07 4721 5511

Maternal and child health

Community Child Health Services:
www.health.qld.gov.au/cchs
If you require help to locate a service, use the 24 hour help line 13 HEALTH (13 43 25 84)
https://access.health.qld.gov.au/QFinder

Community Child Health 1300 366 039

Refugee Maternity Service: Mater Mothers' Hospital

Midwife 0434 189 102

Social Worker 07 3163 8031

Antenatal Clinic 07 3163 8330

Mental health services

For a full list of state wide public mental health services across all health districts: www.health.qld.gov.au/mentalhealth/docs/mhservices_directory.pdf

Princess Alexander Mental Health Triage Service 1300 858 998
www.health.qld.gov.au/pahospital/mentalhealth/default.asp

Queensland Transcultural Mental Health Centre (QTMHC)
07 3167 8333
F: 3167 8322
Outside Brisbane metro areas: 1800 188 189
www.health.qld.gov.au/pahospital/qtmhc/
tccs@health.qld.gov.au

State Wide Multicultural Mental Health Program employs Multicultural Mental Health Coordinators across several Health Service Districts to provide support and improve access to mental health care for people from culturally and linguistically diverse backgrounds. For more information contact the State Wide Liaison and Policy Coordinator: Greg Turner 07 3167 8333
F: 07 3167 8322.
www.health.qld.gov.au/pahospital/qtmhc/partnership.asp
1800 188 189

Mater Child and Youth Mental Health Services (CYMHS)
07 3840 1640
www.kidsinmind.org.au

Targeted Community Care (Mental Health)
Includes Personal Helpers and Mentors (recovery based community mental health support), Mental Health Respite: Carers support and Family Mental Health Support service (early intervention mental health program)
www.fahcsia.gov.au/sa/mentalhealth/progserv/Pages/default.aspx

Multilingual and multicultural health resources

Refugee Health Queensland (RHQ) 07 3163 2880
www.refugeehealthqld.org.au

Queensland Health – Multicultural
www.health.qld.gov.au/multicultural

Mental Health in Multicultural Australia (Information for Health Professionals)
www.mhima.org.au

Beyond Blue 1300 22 4636
www.beyondblue.org.au/

Resources on depression in a variety of languages

Ethnic Communities Council of Queensland (ECCQ)
07 3844 9166 F: 073846 4453
www.eccq.com.au administration@eccq.com.au

Multicultural Development Association (MDA) 07 3337 5400
www.mdainc.org.au
mailbox@mdabne.org.au

Health Coalition 07 3387 5370

Queensland Transcultural Mental Health Centre
07 3167 8333
F: 07 3167 8322

Transcultural Ed-LinQ Initiative: statewide service which provides an information, referral, resource and clinical consultation service
1800 188 189
www.health.qld.gov.au/pahospital/qtmhc/default.asp

Nutrition

Refer to nutritionist at nearest hospital.

Eight Mile Plains Community Health Nutrition Unit, Promotion and Training 07 3169 9800
For helpful resources: http://www.health.qld.gov.au/multicultural/health_workers/nutritn_res.asp
For a list of nutritionists in regional Queensland see:
www.healthier.qld.gov.au/search/node/nutritionist

Older refugees

Diversicare (in home care for frail aged and carers) 07 3846 1099
F: 3846 1077
info@diversicare.com.au

Cairns 07 4054 5653
F: 4049 4602
cairns@diversicare.com.au

Townsville 07 4723 1470
F: 4723 8492
townsville@diversicare.com.au

SPIRITUS Toowoomba 07 3421 2800 or 1300 785 853
www.spiritus.org.au/WHATWEDO/MigrantsandRefugeeSupport.aspx
info@spiritus.org.au

Optometry

Refugees are entitled to access the Spectacle Supply Scheme administered by the **Medical Aids Subsidy Scheme (MASS)** for the first six months after arrival. They are exempt from the waiting period. For a list of participating optometrists state wide who bulk bill and participate in the scheme see:
www.health.qld.gov.au/mass/spectacles.asp

Psychological support and counselling/ torture and trauma

Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT) 07 3391 6677 F: 07 3391 6388
www.qpastt.org.au
admin@qpastt.org.au

QPASTT services Brisbane, Cairns, Rockhampton, Toowoomba and Townsville. Referral form available online.

Multicultural Centre for Mental Health and Wellbeing: Harmony Place 07 3848 1600 F: 07 3848 1699
www.harmonyplace.org.au
admin@harmonyplace.org.au

Mercy Family Services
www.mercyfamilyservices.org.au

Support for unaccompanied refugee minors and support, counselling, and mediation for refugee youth

Brisbane 07 3267 9000
F: 07 3267 0569

Toowoomba 07 4617 7600
mfs.admin@mfsq.org.au

Immigrant Women's Support Service (IWSS)
www.iwss.org.au

Sexual Assault Program 07 3846 5400 F: 07 3846 5619
mail@iwss.org.au

Centacare Cairns 07 4041 7699

Townsville Multicultural Support Group 07 4775 1588

Lifeline (24hr) telephone counselling 13 11 14

Refugee and immigrant health services

Refugee Health Queensland (RHQ)
http://www.materonline.org.au/Home/Services/Refugee-health/Refugee-Health-Queensland.aspx

A statewide service, which includes a central hub for clinical support, planning, service coordination and administration and 6 health assessment clinics in key refugee settlement areas.
refugeehealthqld@mater.org.au

INITIAL ASSESSMENT SERVICES

Brisbane South Clinic (incorporates the former QIRCH clinic)
07 3163 2880

Cairns Clinic 07 4226 4333
Logan Clinic 07 3290 8900
Toowoomba Clinic 07 4616 6446
Townsville Clinic 07 3163 2880
Zillmere Clinic 1300 366 039

The above clinics are funded and supported by RHQ but operate independently via a range of health services. The clinics vary in scope and capacity but the main focus is on:

- Standard health assessments, including catch-up vaccination
- Supported referral to existing services, in particular General Practice

COMPLEX CASE SERVICES

Brisbane South Clinic also provides an "Extended Care" stream of service (formerly QIRCH Clinic) where experienced GPs assist in the short term management of complex clinical cases. To download a referral form refer to www.refugeehealth.qld.org.au

Settlement services

Community based services funded to provide case management and community support to refugees regarding accessing services, e.g., housing, education, Centrelink, etc. Information and referrals also provided.

SETTLEMENT SUPPORT FOR THE FIRST SIX MONTHS

(Brisbane) Multicultural Development Association (MDA)
07 3337 5400 F: 07 3337 5444
www.mdainc.org.au mailbox@mdabne.org.au

(Logan) A.C.C.E.S. Services Inc. 07 3412 8222
F: 07 3412 8220
www.accesservicesinc.org.au/

(Logan) Multilink Community Services 07 3808 4463
F: 07 3808 6337
www.multilink.org.au

(Toowoomba) Multicultural Development Association
07 4639 3983

(Cairns) Migrant Settlement Services, Centacare Cairns
07 4041 7699

(Townsville) Multicultural Support Group 07 4775 1588

For a full list of organisations funded to provide settlement support from 6 months to 5 years see: www.immi.gov.au/living-in-australia/delivering-assistance/settlement-grants/2011-12-grants-recipients.htm

Sexual assault

Statewide Sexual Assault Helpline 1800 010 120

Immigrant Women's Support Service (IWSS) 07 3846 5400

Crisis Care (24 hours) 1800 010 120

Sexual health

Brisbane Sexual Health Clinic 07 3837 5611
bshc@health.qld.gov.au

Princess Alexandra Sexual Health Clinic 07 3240 5881
pash@health.qld.gov.au

Cairns Sexual Health Clinic 07 4050 6205
cairnsshs@health.qld.gov.au

Rockhampton Sexual Health & HIV Service 07 4920 5555
sandrock_house@health.qld.gov.au

Toowoomba - Kobi House, Dept. of Public Medicine
07 4616 6446

Townsville – Sexual Health Unit 07 4778 9600
Rose_Gordon@health.qld.gov.au

For a full listing of Queensland Health sexual health services and community based organisations see:
www.health.qld.gov.au/sexhealth/help/default.asp#other

Other key services

BARC – Brisbane Actionweb for Refugee Collaboration
www.barc.org.au/
Includes resource directory for refugee services in Brisbane

Islamic Women's Association 07 3208 6333
F: 07 3208 6933
www.iwaq.org.au

St Vincent de Paul Society 07 3010 1000
F: 07 3010 1098
www.vinnies.org.au/home-qld

Centre for Multicultural Pastoral Care 07 3109 6810
F: 3109 6829
www.multiculturalcare.org.au cmpc@bne.catholic.net.au

Toowoomba Refugee and Migrant Support Centre 07 4613 0895

Inala Community House 07 3372 1711
F: 3278 7238 ich@ich.org.au
www.bswnc.org.au/ich/

Kyabra Community Association Inc. (Sunnybank) 07 3373 9499
F: 3373 9444
www.kyabra.org
kyabra@kyabra.org

Multilink Community Services (Logan) 07 3808 4463
F: 07 3808 6337
www.multilink.org.au info@multilink.org.au

South Australia

Asylum seekers

Australian Red Cross Asylum Seekers Assistance Scheme (ASAS) and Community Assistance Support (CAS)
08 8100 4642

Child protection services

Women's and Children's Hospital 08 8161 7346

Child Abuse Report Line 131 478

Child and Youth Health Parent Helpline (24 Hours) 1300 364 100

Dental services

Adelaide Dental Hospital 08 8222 8222

Adelaide Hospital Dental Emergency (after hours) 08 8232 1034

Community Dental Service Clinics 08 8222 8284

Disability services

Disability information services 1300 786 117

Disability SA 08 8366 7300

Sensory directions 1800 738 855

Novita children's services 1800 337 443

Royal Society for the Blind of South Australia 08 8232 4777
www.rsb.org.au

All Cultures Respite Options
North West and East-South 08 8234 5557

MALSSA Inc. 08 8351 9500

Metropolitan Domiciliary Care 08 8193 1234
www.domcare.sa.gov.au

Ethnic Link Services 08 8241 0201
www.ucwpa.org.au/community/ethnic-link-services

Independent Living Centre 1300 885 886

Commonwealth Carelink 1800 052 222

Family violence

Domestic Violence Crisis Service 1300 782 200

Domestic Violence Helpline 1800 800 098

Migrant Women's Support and Accommodation Service
08 8346 9417
admin@mwsas.com.au

Crisis Care 131 611

Female genital mutilation

Women's Health Statewide 08 8239 9600
www.whs.sa.gov.au

Shine SA 08 8300 5300
www.shinesa.org.au

Migrant Health Service 08 8237 3900

Health practitioner support and advice

Royal Australian College of General Practice 08 8267 8310
www.racgp.org.au

Migrant Health Service 08 8237 3900

Hearing

CHILDREN

The Hearing Assessment Centre 08 8303 1500

ADULTS

Audio Clinics 08 8223 2462

Deaf SA
www.deafcando.com.au

Immunisation

South Australian Immunisation Coordination Unit (information on current catch-up schedules) 08 8226 7177

Migrant Health Service 08 8237 3900

City of Charles Sturt Council 08 8408 1111 (referral only)

Eastern Health Authority 08 8132 3600

Onkaparinga Council 08 8384 0666

Playford Council 08 8256 0333

Port Adelaide Enfield City Council through RDNS 1300 364 264

West Torrens Council 08 8416 6333 (referral only)

Infectious diseases

Adelaide Chest Clinic 08 8222 5307
(Clients may self refer) 08 8222 5429

Infectious Diseases Clinic/clinic 275 08 8222 2954
(All clients must be referred by a medical practitioner)

Migrant Health Services 08 8237 3900

Interpreters/language services

Translating and Interpreting Service (TIS) National 131 450

TIS Doctors' Priority Line 1300 131 450

TIS National Client Code registration form
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm

TIS interpreter booking forms
On-site www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/booking.htm

Pre-booked telephone interpreterwww.immi.gov.au/living-in-australia/help-with-english/help_with_translating/_pdf/request-pre-booked-telephone-interpreter.pdf

Fee for service Interpreting

ABC International 08 8364 5255

ITC 08 8226 1990

ONCALL Interpreting Service 08 8410 5111

Legal centres

Legal Services Commission 08 8463 3555
www.lsc.sa.gov.au

Central Community Legal Service 08 8342 1800

Northern Community Legal Service 08 8281 6911

Southern Community Justice Centre 08 8384 5222

Welfare Rights Centre (SA) 08 8226 4123

Westside Community Lawyers 08 8243 5521

Women's Legal Service (SA) 08 8221 5553

Migration advice

Legal Services Commission 08 8463 3555
www.lsc.sa.gov.au

Australian Refugee Association 08 8354 2951

Migration Options pty ltd 08 8410 1248

Migration Prospects (private practice) 0434 284 353

Maternal and child health

Child and Youth Health 08 8303 1500

Child and Youth Health Parent Helpline (24 hours) 1300 364 100

Mental health services (adult)

Assessment and Crisis Intervention Service (24 hours) 131 465

QEH Centre for Treatment of Anxiety & Depression
08 8222 8100

Migrant Health Service 08 8237 3900

Mental Illness Fellowship SA (MIFSA) 08 8378 4100
Personal Helpers and Mentor Program for Humanitarian Entrants

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) 08 8206 8900
sttars@sttars.org.au

Mental health services (child and adolescent)

Child and Adolescent Mental Health Services (CAMHS)

Northern CAMHS 08 8252 0133

Eastern CAMHS 08 7321 4500

Western CAMHS 08 8341 1222

Southern CAMHS

Marion 08 7425 8600

Mt Barker 08 8391 3922

Onkaparinga 08 8326 1234

Women and Children's Hospital Department of Psychological Medicine 08 8161 7227

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) 08 8206 8900

Older refugees

Ethnic Link Services 08 8241 0201

Multicultural Aged Care 08 8241 9900

Optometry

Any Optometrist (all bulk bill)

Royal Adelaide Hospital Eye Clinic 08 8222 5911
(Appointments allocated following receipt of written referrals)

Primary health care services

Migrant Health Services 08 8237 3900

Aldinga GP Plus Health Care Centre 08 8557 9500

Elizabeth GP Plus Health Care Centre 08 7485 4000

Marion GP Plus Health Care Centre 08 7425 8200

Modbury GP Plus Super Clinic 08 8261 5476

Morphett Vale GP Plus Health Care Centre 08 8325 8100

Noarlunga Village Primary Health Care Services 08 8384 9266

Parks Primary Health Care Services 08 243 5611

Playford North GP Super Clinic 08 8254 4500

Port Adelaide Primary Health Care Services 08 8240 9611

Port Adelaide Women's Health Services 08 8444 0700

Salisbury Primary Health Care Service 08 8281 7644

Woodville GP Plus Health Care Centre 08 300 5300

Psychological support and counselling

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) 08 8206 8900

Migrant Health Services 08 8237 3900

Refugee and immigrant health services

Migrant Health Service 08 8237 3900

Settlement services

Migrant Resource Centre 08 8217 9500
www.mrcsa.com.au

Australian Refugee Association 08 8354 2951
www.australianrefugee.org

Sexual assault

Yarrow Place 08 8226 8777
www.yarrowplace.sa.gov.au

Sexual and reproductive health

Sexual Health Information, Networking and Education SA (SHINE SA) 08 8300 5300

Dale St Women's Health Service 08 8444 0700

Migrant Health Service 08 8237 3900

Other key services/resources promoting refugee health

South Australian Refugee Health Network
www.sarhn.org.au

Tasmania

Asylum Seekers

DIAC Hobart 03 6220 4227

Australian Red Cross Asylum Seekers Assistance Scheme (ASAS) and Community Assistance Support (CAS)
03 6235 6029

Child health clinics and parenting services

Parenting Line (24 hours) 1300 808 178
Call regional offices for information on Child Health Clinics in your area. See White Pages under 'Health'

Burnie 03 6434 6451

Devonport 03 6421 7800

Hobart 03 6230 7899

Launceston 03 6336 2130

Pregnancy Counselling & Support (TAS) Inc. 03 6224 2290

Pregnancy Help Line (after hours) 1300 655 156

Child protection services

Child Protection Advice & Referral Service 1300 737 639
After hours (Child Protection Assessment Board) 1800 001 219

Community health centres

For Community Health Centres in your area 1300 135 513.
See White Pages under 'Health'

Dental services

Oral Health Services Hotline 1800 814 702
For information and referral to the nearest clinics statewide see White Pages under 'Health'

Disability services

Hobart 03 6230 7600

North 03 6336 4130

North West 03 6434 4103

Family planning

Family Planning Tasmania

Healthline 1300 658 886
www.fpt.asn.au

Hobart 03 6273 9117

Launceston 03 6343 4566

Burnie 03 6431 7692

Family violence

Domestic Violence Crisis Service 1800 608 122

Family Violence Response & Referral Line 1800 633 937

Female genital mutilation (FGM)

FGM Education Program 1800 675 028
via DHHS Women's Health Service Directory

General practice divisions

General Practice North 03 6331 9296
www.gpnorth.com.au

General Practice South 03 6208 7300
www.gpsouth.com.au

General Practice North-West 03 6425 0800
www.gpnw.com.au

Hearing

Tasmanian Hearing Services 1800 423 449

Tasmanian Deaf Society www.tasdeaf.org.au

Hobart 03 6231 6501

Launceston 03 6331 9766

Immunisation

Immunisation Hotline 1800 671 738

Australian Childhood Immunisation Register 1800 653 809

Infectious diseases

Royal Hobart Hospital Refugee and Humanitarian Arrival Clinic (RAHAC) 03 6222 8636

Launceston General Hospital 03 6348 7202

Hepatitis Info Line 1300 437 222

Infectious Diseases Information via DHHS Public & Environmental Health Service 1800 671 738

Tasmanian Council on AIDS, Hepatitis & Related Diseases (tasCAHRD) 1800 005 900

Sexual Health Service 1800 675 859

Infectious diseases (Tuberculosis)

Hobart 03 6222 7293

Launceston 03 6348 7202

Devonport 03 6421 7700

Interpreters/language services

Translating and Interpreting Service (TIS) National 131 450

TIS Doctors' Priority Line 1300 131 450
(normal wait time 3 minutes)

TIS National Client Code registration form
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm

TIS interpreter booking forms
On-site www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/booking.htm

Pre-booked telephone interpreterwww.immi.gov.au/living-in-australia/help-with-english/help_with_translating/_pdf/request-pre-booked-telephone-interpreter.pdf

Amigos 03 6228 5480

Language Link 03 6344 7831

All World Languages 03 6224 5355

Legal services

Community Legal Services

Hobart 03 6223 2500

Launceston 1800 066 019

North West 03 6424 8720

Women's Legal Service 1800 682 468

Legal Aid Commission of Tasmania Telephone Advice Service 1300 366 611

Mental health services (adult)

Statewide Triage Referrals 1800 332 388

Multicultural Health & Wellbeing Policy Officer 03 6222 7656

Mental health services (child and adolescent)

Statewide Triage Referrals 1800 332 388

North 03 6336 2867

North-West 03 6434 7280

South 03 6233 8612

Migrant resource centres

Northern Tasmania 03 6331 2300

Southern Tasmania 03 6221 0999

North-West Tasmania 03 6423 5598

Nutrition

Community Nutrition Unit (statewide) 03 6222 7222

Older refugees

See Migrant resource centres (above)

Community Care (NESB) 03 6334 0990

Optometry

Spectacle Assistance Scheme 1800 232 148

Psychological support and counselling

(Specialist support services for survivors of torture and trauma)

Migrant Resource Centre Launceston 03 6331 2300

Hobart – Phoenix Centre 03 6234 9138

Refugee health assessment services

REFUGEE & HUMANITARIAN ARRIVAL CLINIC (RAHAC)

Royal Hobart Hospital 03 6222 8636

Launceston General Hospital 03 6348 7202

REFUGEE ARRIVAL HEALTH ASSESSMENT CLINIC

Refugee Primary Health Care Clinic (GP North) 03 6332 2238

Migrant Resource Centre 03 6331 2300

Settlement services

Centacare – Hobart 03 6278 1660

Colony 47 1800 265 669

Migrant Resource Centres

Launceston 03 6331 2300

Hobart 03 6221 0999

Burnie/Devonport 03 6223 5598

Sexual assault

Hobart Sexual Assault Support Service 03 6231 1811
Crisis line (24 hours) 03 6231 1817

Launceston Sexual Assault Support Service 03 6334 2740
After hours 0409 800 394

North-West Centre Against Sexual Assault 03 6431 9711

Youth health

Alcohol and Drug Service 1300 139 641
Free call (24 hours) 1800 811 994

Eating Disorders Hotline 1800 675 028

Colony 47 (Emergency Accommodation) 1800 265 669

Health Department 1300 135 513

The Link Youth Health Service 03 6231 2927

Victoria

For up to date referral information visit
www.refugeehealthnetwork.org.au

Asylum seekers

Australian Red Cross Asylum Seekers Assistance Scheme (ASAS) and Community Assistance Support (CAS) 03 8327 7700
www.redcross.org.au/asylum-seeker-assistance-scheme.aspx

Asylum Seeker Project Hotham Mission 03 9326 8343
www.hothammission.org.au

Asylum Seeker Resource Centre 03 9326 6066
GP clinic (Mon–Fri, 10am–12pm)
Nursing clinic (Mon–Fri, 1.30pm–3pm)
www.asrc.org.au

Dandenong Hospital outpatient refugee health centre
03 8792 2200

Cardinia Casey Asylum Seekers and Refugee Health Clinic (Doveton) (Mon and Wed, 9am–5pm, Thurs, 9am–1pm)
03 9212 5700

Asylum Seeker Welcome Centre Brunswick 03 9388 2459
http://aswc.org.au/home (No medical services)

Medicare ineligible asylum seekers are to be provided with full medical care including, pathology, diagnostic, pharmaceutical and other services in Victorian hospitals. Asylum seekers are eligible for free ambulance transport, and assistance with home care and catch-up immunisation.

Asylum seekers have priority access to community health centres and dental services.

For information see: http://docs.health.vic.gov.au/docs/doc/Guide-to-asylum-seeker-access-to-health-and-community-services-in-Victoria

Access to public health services for asylum seekers in community detention: http://docs.health.vic.gov.au/docs/doc/Guidelines-for-Victorian-Public-Health-Services-on-Community-Detention

Child Protection services

Child Protection Services (24 hours) 131 278
Regional services see www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection/child-protection-contacts

Community health centres

Addresses of community health centres can be found in this directory:
www.health.vic.gov.au/communityhealth/service_provider/community_health_directory.htm

Refugee Health Nurses are located in community health services in areas of significant refugee settlement. **To contact your local Refugee Health Nurse please use the following numbers**:

METRO MELBOURNE

Cardinia Casey CHS (Southern Health) 03 9212 5700
F: 03 9212 5711

Dandenong CHC (Southern Health) 03 8792 2255
F: 03 8792 2288

Dandenong CHC (Springvale site) (Southern Health)
03 8558 9133 F: 03 8558 9138

Darebin CHC 03 8470 1172 F: 03 9478 9647

Dianella CHC 03 8345 5434 F: 03 9309 2422

Doutta Galla CHC 03 83781625 F: 03 9372 1558

ISIS Primary Care Brimbank 03 9313 5037 F: 03 9313 5050

ISIS Primary Care Wyndham 03 8734 1427 F: 03 9313 5050

Eastern Access Community Health (EACH) 03 9837 3979
F: 03 9879 6356

Western Region Health Centre 03 8398 1445 F: 03 9687 9330

REGIONAL AND RURAL

Ballarat CHC 03 5338 4554

Bendigo CHC 03 5434 4300

Castlemaine CHC 03 5479 1000

Geelong Barwon Health 03 5260 3809

Goulbourn Valley Health 03 5267 1200

La Trobe CHC 03 5171 1406

Sunraysia CHS 03 5022 5444

Wonthaggi CHC 03 5671 9200

Dental services

Dental Health Services Victoria 1300 360 054
or see www.dhsv.org.au

Royal Dental Hospital
03 9341 1000
Outside Melbourne 1800 833 039
(Emergency treatment only 8am–9.15pm)

Emergency 24 hour care for children 03 9345 5344
www.rch.org.au/dentistry

Disability services

Action on Disability within Ethnic Communities (ADEC)
03 9480 1666 or 1800 626 078
provides support for people from non-English speaking background with a disability and their carers

Centrelink 13 2717
Provides people with disabilities and their carers with certain financial benefits

Association for Children with a Disability 03 9818 2000
www.acd.org.au/about_us/index.htm

Family planning

Family Planning Association Victoria 03 9257 0121
www.fpv.org.au/

Family violence

EMERGENCY ACCOMMODATION (24 hours)
Women's Domestic Violence Crisis Service 03 9322 3555
24/7 crisis line 1800 015 188

COUNSELLING, SUPPORT AND ACCOMMODATION

InTouch Multicultural Centre Against Family Violence
03 8413 6800 or 1800 755 988
www.intouch.asn.au

Barwon Domestic Violence Outreach Service Geelong
03 5224 2903

Eastern Domestic Violence Outreach Service Ringwood
03 9870 5939

Northern Family and Domestic Violence Service (Berry Street)
03 9450 4700

Southern Domestic Violence Outreach
Frankston 03 9781 4658
Cranbourne 03 5990 6789
Dandenong 03 9791 6111
Narre Warren 03 9703 0044

Women's Health West Domestic Violence Outreach Service
Footscray 03 9689 9588

Female genital mutilation

Family and Reproductive Rights Education program (FARREP)
03 8345 3058
www.thewomens.org.au/farrep

Royal Women's Hospital Deinfibulation Clinic 03 8345 3037 or
03 8345 3045
1800422 007 (rural callers)
F: 03 83453036 (referrals)
www.thewomens.org.au/FemalecircumcisionDeinfibulationClinic

For clinical advice and referral contact obstetric or gynaecology registrar at:
Mercy Hospital for Women 03 8458 4444
Monash Medical Centre 03 9594 6666
Royal Women's Hospital 03 8345 2000

General practice divisions

General Practice Victoria 03 9341 5200
www.gpv.org.au

For all practice divisions and Medicare Locals in Victoria contact General Practice Victoria.

Hearing

The Australian Government Hearing Service
Client Eligibility Advice
1800 500 726

Australian Hearing 131 797
www.hearing.com.au

For children and young adults up to the age of 21 years, who are permanent residents of Australia

HEAR Services
Free preliminary hearing tests for adults. Check with local Community Health Centre.

Victorian Deaf Society
03 9473 1111
www.vicdeaf.com.au

Immunisation

Immunisation Catch-Up Guide 1300 882 008
www.health.vic.gov.au/immunisation/quick-guide-catch-up.htm

Immunisation Clinic Royal Children's Hospital 03 9345 6599

Translated immunisation resources
www.health.vic.gov.au/immunisation/factsheets/language.htm

For advice on clinical/laboratory matters:
Victorian Infectious Diseases Reference Laboratory
03 9342 2600

Immunisation Register Health Insurance Commission
1800 653 809

For information on the vaccination history of individual children (nominated vaccination providers only)

Infectious diseases

GOVERNMENT SERVICES

Infectious Diseases Epidemiology & Surveillance Public Health Branch
www.health.vic.gov.au/ideas/

Communicable Disease Prevention and Control Unit
1300 651 160
Notification 1300 651 160
Emergency 1300 790 733

CLINICAL ASPECTS AND REFERRAL – MELBOURNE METRO

Victorian Infectious Diseases Service (VIDS) at Royal Melbourne Hospital 03 9342 7212
Refugee Health Fellows: Paediatric 03 9345 5522
GP Fellow 03 9342 7000
Immigration/Refugee Clinic on Tuesday mornings 9am-midday

Royal Melbourne Hospital Infectious Diseases Registrar
03 9342 7000

Royal Children's Hospital Immigrant Health Clinic
(ask for clinic coordinator) 03 9345 5522
www.rch.org.au/immigranthealth

CLINICAL ASPECTS AND REFERRAL – LOCAL

Alfred Hospital Infectious Diseases Clinic 03 9276 6081
Clinical support for people with HIV, hepatitis C and STIs.

Austin Health Infectious Diseases unit 03 9496 6676

Department of Infectious Diseases & Clinical Epidemiology, Monash Medical Centre 03 9594 4564

HIV CALD Service – Alfred Health 03 9076 3942

St Vincent's Hospital 03 9288 2211

Western Hospital 03 9319 6666

CLINICAL SERVICES AND REFERRAL – REGIONAL AND RURAL

Ballarat Community Health Centre 03 5338 4554

Bendigo Outpatients Department Infectious Diseases 03 5454 8422

Geelong Hospital Immigrant and Refugee Health Clinic (Tues morning) 03 5226 7254

Shepparton Medical Centre – adult infectious diseases and refugee health 03 5823 3100

CLIENT INFORMATION AND SUPPORT

Multicultural Health and Support Service (MHSS) 03 9342 9700
www.ceh.org.au/mhss

A community service that provides information and support to culturally and linguistically diverse communities (CALD) affected by issues related to HIV, hepatitis C and STIs.

Interpreters/language services

Translating and Interpreting Service (TIS) National 131 450

TIS Doctors' Priority Line 1300 131 450
(normal wait time 3 minutes)

TIS National Client Code registration form
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm

TIS interpreter booking forms
On-site www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/booking.htm

Pre-booked telephone interpreter www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/_pdf/request-pre-booked-telephone-interpreter.pdf

Hospitals and large scale users receive direct funding to purchase language services. It is the responsibility of these services to organise their own interpreting services, typically from one or more of the language service companies (TIS, ONCALL, VITS or All Graduates) or directly employing accredited interpreters.

See the Department of Human Services Language Services Credit Line for more information www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/language-services-credit-line-guidelines

FEE FOR SERVICE

On call 03 9867 3788

VITS 03 9280 1955 (bookings)

All Graduates 1300 739 731

Ethnologue – online portal of languages of the world
www.ethnologue.com

Eastern Health Cue Cards – these cue cards may help with instructions in your clinic
www.easternhealth.org.au/services/cuecards/default.aspx

Legal centres

Refugee and Immigration Legal Centre (RILC) Fitzroy
03 94130101
Advice line 03 94130100
www.rilc.org.au

Victorian Legal Aid 03 9269 0120
www.legalaid.vic.gov.au
Community Legal Centres see White Pages

Maternal and child health

Maternal and Child Health Line (24 hours) 132 229
www.office-for-children.vic.gov.au/maternal-child-health

Mental health services (adult)

Victorian Mental Health Services: Accessing Services Directory
www.health.vic.gov.au/mentalhealth/services/index.htm

Refugee Mental Health Clinic (at Foundation House)
03 9388 0022
www.foundationhouse.org.au

Victorian Transcultural Psychiatry Unit (VTPU) 03 9288 3300
www.vtpu.org.au

Action on Disabilities within Ethnic Communities (ADEC)
03 9480 1666
or 1800 626 078
www.adec.org.au

Mental Health services (child and adolescent)

Child and Adolescent Mental Health Service Directory
www.health.vic.gov.au/mentalhealth/services/child/index.htm

Early Psychosis Prevention and Intervention Centre (EPPIC)
Orygen Youth Health 03 9342 2800
(AH) 1800 888320
www.eppic.org.au

Headspace National Youth Mental Health Foundation
www.headspace.org.au to find a local service

Multilingual and multicultural health resources

MyLanguage
www.mylanguage.gov.au/translated-information/health.html

A national portal of multilingual resources, including health and settlement information.

Victorian Department of Health – Immunisation in your language resources
www.health.vic.gov.au/immunisation/factsheets/language.htm

Victorian Government Health Translations Directory
www.healthtranslations.vic.gov.au

Victorian Transcultural Psychiatry Unit (VTPU) 03 9288 3300
www.vtpu.org.au

Nutrition

For clinical advice contact a specialist Immigrant Health Clinic listed under 'Infectious diseases'.

Optometry

Australian College of Optometry appointments 03 9349 7400

Darebin Community Health Service 03 9478 5711

Broadmeadows Health Service 03 8345 5414

Casey Community Health Service 03 9791 5700

Eastern Access Community Health (Mon-Wed) via Refugee Health Nurse 03 9837 3999

ISIS Primary Care Wyndham (Fri once a month) 03 8734 1400

Western Health 03 8345 6666

Western Region Health Braybrook 03 9334 6622

Or refer to a bulk-billing optometrist.

Psychological support and counselling

The Victorian Foundation for Survivors of Torture (Foundation House)
All referrals should be directed to the **Brunswick Office**
03 9388 0022
For regional and rural referrals contact **Rural Liaison Officer**
03 9389 8962
www.foundationhouse.org.au

Offices in Brunswick, Dandenong, Ringwood and Sunshine.

Psychiatric disability rehabilitation and support services (PDRSS) Accessing Services Directory
www.health.vic.gov.au/mentalhealth/services/disability

Contact your nearest public hospital for information on local mental health team.
For mental health services in your area please visit this website and search by suburb name:
www.health.vic.gov.au/mentalhealth/services/index.htm

Refugee & immigrant health services

See also Refugee Health Nurse Program under Community health centres.

Victorian Infectious Diseases Service (VIDS) at Royal Melbourne Hospital 03 9342 7212
Immigration/Refugee Clinic (Tues, 9am–12pm)

Royal Melbourne Hospital Infectious Diseases Registrar
03 9342 7000

Royal Children's Hospital Immigrant Health Clinic
(ask for clinic coordinator) 03 9345 5522
www.rch.org.au/immigranthealth

Asylum Seeker Resource Centre 03 9326 6066
GP clinic (Mon–Fri, 10am–12pm)
Nursing clinic (Mon–Fri, 1.30pm–3pm)
www.asrc.org.au

WEST METRO MELBOURNE

The Western Region Health Centre 03 8398 4149
Infectious diseases clinic (3 Wed afternoons per month), paediatric clinic and vitamin D clinic (3 Tues per month), refugee community mental health workers clinic (Mon-Thurs) and outreach clinic (one Tues per month).

ISIS Primary Care Sunshine 03 9313 5000
F: 03 9313 5050
Paediatric clinic and vitamin D clinic
(alternate Thurs, 9am–12.30pm)

ISIS Primary Care Wyndham 03 8734 1400
Adult infectious diseases and refugee health clinic
(monthly clinic Wed afternoon).

Doutta Galla Community Health 03 8378 1600
Nursing clinic, refugee health assessment and mothers playgroup.

NORTH METRO MELBOURNE

Darebin Community Health Centre 03 8470 1172
Refugee paediatric and vitamin D clinic (Third Monday of month).

EAST METRO MELBOURNE

Eastern Access Community Health (EACH)
Social and community health 03 9387 3999
Women's health clinic and Monthly Mantoux Optometry and audiology (Mon–Wed)

SOUTH EAST METRO MELBOURNE

Dandenong Hospital Outpatient Refugee Health Clinic
03 9554 1009
Infectious diseases clinic, paediatrics, women's health, child and adolescent health, mental health services and a dietitian
(Mon, 1.30pm–4.30pm)
Appointments only available by GP referral F: 03 9554 8554

Cardinia Casey Asylum Seeker and Refuge Health Clinic – Doveton site 03 9212 5700
GPs, community health services, refugee mental health psychiatric registrar (Mon and Wed, 9am–5pm, Thurs, 9am–1pm)

RURAL VICTORIA

Ballarat Community Health Centre 03 5388 4554
Immigrant paediatric health clinic, also adult vitamin D clinic (first Tues afternoon of month).

Shepparton Medical Centre 03 5823 3100
Adult infectious disease and refugee health clinic (monthly clinic on Tues)

Geelong Hospital Refugee Health Clinic 03 5226 7254
F: 03 5246 5143
Infectious diseases and paediatrics (Tues morning).

Bendigo Outpatients Department Fax referral to outpatient triage
03 54548922
Infectious diseases clinic (monthly Wed).

Settlement services

HUMANITARIAN SETTLEMENT SERVICES (HSS)

Adult Multicultural Education Services (AMES) HSS Consortium
www.ames.net.au

South East Melbourne and Gippsland 03 8558 8870
Western and Inner Melbourne 03 9680 0177
North Eastern suburbs 03 9356 6200
Rural and Regional Victoria 03 9926 4744

Settlement Grant Providers (SGPs)
www.immi.gov.au/living-in-australia/delivering-assistance/settlement-grants/funded-orgs.htm

Sexual assault

After hours telephone counselling service 03 93491 766 or 1800 806 292

Sexual Assault Services
www.casa.org.au

CASA House Carlton 03 9635 3610
Eastern CASA East Ringwood 03 9870 7330
Barwon CASA Geelong 03 5222 4802
Northern CASA Austin Hospital Heidelberg 03 9496 2240
South Eastern CASA Bentleigh 03 9594 2289
West CASA Footscray 03 9687 8637
South Western CASA Warnambool 03 5564 4144
Gippsland CASA 03 5134 3922
Goulbourn Valley CASA 03 5831 2343
Mallee Sexual Assault Unit 03 5025 5400
Ballarat CASA 03 5320 3933
Bendigo CASA 03 5441 0430

Sexual health

Melbourne Sexual Health Centre 03 9341 6200
Free call outside Melbourne 1800 032 017
www.mshc.org.au

Learning and professional development

Victorian Foundation for Survivors of Torture (Foundation House)
03 9388 0022
www.foundationhouse.org.au

Centre for Culture Ethnicity and Health (CEH) 03 9342 9700
www.ceh.org.au

Victorian Transcultural Psychiatry Unit (VTPU) 03 9288 3300
www.vtpu.org.au

Other key services/resources promoting refugee health

Refugee Council of Australia (Melbourne office) 03 9600 3302

Victorian Government Refugee Health and Wellbeing Strategy 2005-2008
www.dhs.vic.gov.au/multicultural/html/refugee_action.htm

The Victorian Refugee Health Network
www.refugeehealthnetwork.org.au

Western Australia

Asylum seekers

Australian Red Cross Asylum Seekers Assistance Scheme (ASAS) and Community Assistance Support (CAS)
08 9225 8888 or
1800 810 710
www.redcross.org.au

Southern Communities Advocacy Legal and Education Service (SCALES) 08 9550 0400
www.law.murdoch.edu.au/scales/

Child protection services

Department for Child Protection 08 9222 2555
www.childprotection.wa.gov.au

Department for Communities 08 6551 8700
www.communities.wa.gov.au

Crisis Care 08 9223 1111
Free call (24 hours) 1800 199 008

Princess Margaret Hospital Child Protection Unit 08 9340 8646

Dental services

Dental Health Services 08 9313 0555
www.dental.wa.gov.au

Disability services

Health Resource and Consultancy – Disability Services Commission 08 9426 9200
1800 998 214
www.dsc.wa.gov.au

Ethnic Disability Advocacy Centre (EDAC) 08 9388 7455 or 1800 659 921
www.edac.org.au

Family planning

FPWA Sexual Health Services 08 9227 6177
www.fpwa.org.au

Family violence

Women's Health and Family Services 08 6330 5400
Free call outside WA 1800 998 399

Range of support services, including domestic violence support

Female genital mutilation

Sexual Assault Resource Centre (SARC)
08 9340 1828 (24 hours/Emergency)
Free call 1800 199 888
www.kemh.health.wa.gov.au

Princess Margaret Hospital Child Protection Unit 08 9340-8646

General practice divisions

Osborne Division of General Practice 08 9201 0044
www.ogpn.com.au

Canning Division of General Practice 08 9458 0505
www.canningdivision.com.au

Rockingham Kwinana Division of General Practice
08 9439 9500
www.rkdgp.com.au

Hearing

Australian Hearing 131 797
www.hearing.com.au

WA Deaf Society 08 9441 2677
www.wadeaf.org.au

Immunisation

Central Immunisation Clinic 08 9321 1312 or 08 9388 4878 or 08 9388 4868
www.health.wa.gov.au
www.public.health.wa.gov.au

Infectious diseases

Humanitarian Entrant Health Service (HEHS) 08 9222 8500
www.health.wa.gov.au
accadmin@health.wa.gov.au

Perth Chest Clinic 08 9222 8500
www.health.wa.gov.au
accadmin@health.wa.gov.au

Royal Perth Hospital 08 9224 2244
www.rph.wa.gov.au

Fremantle Hospital 08 9431 2376 after hours 08 9431 2149
www.fhhs.health.wa.gov.au

Paediatric Infectious Disease 08 9340 8222

Interpreters/language services

Translating and Interpreting Service (TIS) National 131 450

TIS Doctors' Priority Line 1300 131 450
(normal wait time 3 minutes)

TIS National Client Code registration form
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm

TIS interpreter booking forms
On-site www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/booking.htm

Pre-booked telephone interpreterwww.immi.gov.au/living-in-australia/help-with-english/help_with_translating/_pdf/request-pre-booked-telephone-interpreter.pdf

WA Interpreters 08 9362 4819
www.wainterpreters.com.au

ON CALL Interpreter and Translating Agency 08 9225 7700
www.oncallinterpreters.com

Legal centres

Case for Refugees 08 9227 7311
www.caseforrefugees.org.au

SCALES 08 9550 0400
www.law.murdoch.edu.au/scales

Legal Aid 1300 650 579
www.legalaid.wa.gov.au
For information about local **Community Legal Centres Association (WA)** 08 9221 9322
www.communitylaw.net

Maternal and child health

Department Of Health and Ageing 08 9222 4222
www.health.wa.gov.au

Health Direct 1800 022 222 (health advice 24 hours)

Ishar Multicultural Centre for Women's Health 08 9345 5335
www.ishar.org.au

Mental health services (adult)

Mental Health Emergency Response Line 1300 555 788

Rural Link 1800 552 002

Peel 1800 676 822

Mental Health – Metro 1300 555 788

Rural/Remote After Hours 1800 552 002
www.mentalhealth.wa.gov.au

Metropolitan Migrant Resource Centre 08 9345 5755
www.mmrcwa.org.au

Youth and Family Centre 08 9344 6788

Clarkson 08 9200 6284

West Australian Transcultural Mental Health Service
08 9224 1760

Fremantle Multicultural Centre 08 9336 8282
www.fmcwa.com.au

Mental health services (child and Adolescent)

Department Of Health
www.health.wa.gov.au
www.healthinsite.gov.au

Health Direct 1800 022 222

Multilingual and multicultural health resources

Office of Multicultural Interests (OMI) 08 6552 1500
www.omi.wa.gov.au

Nutrition

Dietician
Association for Services to Torture and Trauma Survivors (ASETTS) 08 9227 2700
www.asetts.org.au

Older refugees

Australian Asian Association of Western Australia (Inc.)
08 9328 6202
www.aaawa.org.au

Multicultural Aged Care Service WA 08 9346 8149
08 9346 8240

Multicultural Respite Services (MRS) 08 9231 0500
www.omi.wa.gov.au
www.canning.wa.gov.au

Multicultural Services Centre of WA 08 9328 2699

Rainbow – The Multicultural Aged Care Programme
08 9271 2026
www.agedcareguide.com.au

Umbrella Multicultural Community Care Services 08 9275 4411
www.umbrellacommunitycare.com.au

Optometry

Spectacles Subsidy Scheme 08 9222 4222
www.health.wa.gov.au

Psychological support/counselling

Association for Services to Torture and Trauma Survivors (ASETTS) 08 9227 2700
www.asetts.org.au

Centrecare Migrant Services 08 9325 6644
www.centrecare.com.au/catholic-migrant-services

Communicare 08 9251 5777
www.communicare.org.au

Refugee and immigrant health services

North Metropolitan Area Health Service 08 9242 9642
www.nmahsmh.health.wa.gov.au

Paediatric Refugee Health Clinic 08 9340 8222
Clinic (open Mondays only)

Settlement services

DIAC – Humanitarian Settlement Services 131 881
www.immi.gov.au

Centrecare Migrant Services 08 9221 1727
www.centrecare.com.au/catholic-migrant-services/

Metropolitan Migrant Resource Centre 08 9451 1100
08 9325 6644
www.mmrcwa.org.au

Australian Asian Associations of WA (Inc) 08 9328 6202
www.aaawa.org.au

Communicare 08 9251 5777
www.communicare.org.au

Edmund Rice Centre 08 9440 0625 or 089440 1920
www.ercm.org.au

Multicultural Services Centre of WA (Inc) 08 9328 2699
www.mscwa.com.au

Fremantle Multicultural Centre 08 9336 8282
www.fmcwa.com.au

St Vincent De Paul Society Migrant and Refugee Committee
08 9447 7546

The Gowrie 08 9450 5577
www.gowrie-wa.com.au

Regional Settlement Services

Uniting Church in Australia
www.wa.uca.org.au/caring/frontier-services/

Sexual assault

Sexual Assault Resource Centre (SARC) (24 hours/Emergency)
08 9340 1828
Free call 1800 199 888
www.kemh.health.wa.gov.au/services/sarc

Princess Margaret Hospital Child Protection Unit 08 9340 8646

Other key services/resources

The WA Police Service 131 444 (24/7 assistance)
www.police.wa.gov.au

Coalition for Asylum Seekers, Refugees and Detainees Inc (CARAD) 08 9227 7322
www.carad.org.au

WA Refugee Health Interest Group
www.racgp.org.au/guidelines/refugeehealth



Foundation
House
The Victorian Foundation for Survivors of Torture



fasstt
The Forum of Australian Services
for Survivors of Torture and Trauma